Evaluation of
Voluntary Counselling and Testing
in the National Prevention of Mother to Child
Transmission Programme in Thailand

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Preface

It is estimated that in Thailand nearly 1 million women become pregnant each year. According to the national HIV serosurveillance data approximately 1-2% of pregnant women are infected with HIV each year. In 2000 national HIV seroprevalence in pregnant women was reported to be 1.56%. Approximately 15,000 children are born to HIV positive mothers annually. The 4,000 - 5,000 children who would become infected each year in the absence of prevention of mother-infant HIV transmission interventions represent about one seventh of all new HIV infections in Thailand.

Thailand is one of the first countries in the developing world to start implementing a national programme for the prevention of mother to child transmission (PMTCT) of HIV. In many settings counselling is thought to be the key component for the success of this programme. Therefore an evaluation of the voluntary counselling and testing in the national PMTCT programme was commissioned and conducted by our Department.

This evaluation will provide valuable information to health care workers, administrators and policy makers at all levels in Thailand to further improve and sustain the programme. We hope that the evaluation will be of benefit to other countries currently implementing similar prevention programmes.

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Content

Glossary of abbreviations

ANC	Antenatal clinic
ARV	Antiretrovirals
DOH	Department of Health
ELISA	Enzyme-linked immunosorbant assay
FP	Family planning
HIV	Human Immunodeficiency Virus
AIDS	Acquired Immunodeficiency Syndrome
GPA	Gel Particle Agglutination
IUD	Intrauterine device
MCH	Maternal and child health
MTCT	Mother To Child Transmission
NGO	Non-Governmental Organisation
PLHA	Person living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
TB	Tuberculosis
TOP	Termination of pregnancy
VCT	Voluntary Counselling Testing
ZDV	Zidovudine, (also known as AZT)

1. Executive summary

An evaluation of the counselling services associated with the 1-year Prevention to Mother to Child Transmission (PMTCT) programme in regions 3 and 6 was undertaken in June-July 2000. Although there have been many studies looking at various aspects of voluntary counselling and testing (VCT) in PMTCT research settings there is no published data on evaluating VCT in a national PMTCT programme.

In this study UNAIDS tools for evaluating VCT services[i] were adapted for use in Thailand and piloted prior to the evaluation. The tools were found, in general, to be easy to use and acceptable to antenatal clinic (ANC) managers, nurse/counsellors and women attending antenatal clinics.

1. Operational aspects of the VCT/PMTCT programme

Antenatal coverage in both regions is extremely high. In Region 3, 52,968/55,505 (95%) of women giving birth had attended ANC and in Region 6, 71,984/73,365 (98%) of women who delivered had attended ANC. However, of the small percentage of women who did not receive any antenatal care, a disproportionately high number were found to be sero-positive and presented in labour compared with uninfected women (p=<0.001 for both regions). In Region 3, 206/1282 (16%) and in Region 6, 27/520 (5.2%) of *all* seropositive pregnant women presented in labour without having had any antenatal care.

Uptake of VCT was also very high. 40,006/40,607 (99%) of women in Region 3 and 38,699/41,688 (93%) in Region 6 who attended for antenatal care had had an HIV test during or before their current pregnancy. However, despite this high uptake of VCT, only 476/1067 (44%) of seropositive women in Region 3 and 264/493 (54%) in Region 6 who attended ANC, took the full recommended course of ZDV for PMTCT.

ZDV uptake by infants born to HIV positive women was also relatively low, with only 689/1419 (48.6%) of infants from Region 3 and 258/521 (50%) from Region 6 receiving ZDV within the first 48 hours of life.

Reviewing other operational aspects of the PMTCT programme revealed many organisational strengths in the 19 sites visited. The focal person in charge of the PMTCT programme had ensured that there was always at least one trained counsellor in the each antenatal site. However, some sites did not have trained counsellors in labour room and/or the post-partum clinic. In the majority of sites HIV testing during labour and the post-natal periods was offered, for those women who present in labour without having had any antenatal care. VCT training for health staff working on the labour and post-natal wards could therefore be considered.

All sites offered pre-test counselling, either as group or individually. All sites offered individual post-test counselling for HIV positive women. In all except two sites HIV test results were disclosed *only* to the woman tested. However it was noted that at some sites confidentiality in maternal and child health (MCH) services needed strengthening.

The majority of sites charged a fee for antenatal blood screening (including HIV testing). However, in 13/19 sites the cost for HIV testing was covered for all women by social welfare, health card or co-payment.

There was no shortage of ARV supply at any PMTCT sites during the study period. A periodic shortage of HIV tests was noted in some sites.

Few sites actively referred seropositive pregnant women for other emotional care, medical care or social support. This could either reflect a lack of available support services or a lack of recognition of the needs of seropositive women.

Half of the sites acknowledged that the PMTCT programme had increased workload in the antenatal clinic. However it was felt that improving training, ongoing training supervision and support for counsellors was more important than increasing the number of health workers. Most sites noted that an improved training programme with the development of better patient information material was a priority.

Interviews of counsellors

82 counsellors from the 19 sites were interviewed in depth about their counselling roles. 74% of the counsellors working in the PMTCT programme were professional nurses. The majority said that they felt comfortable with PMTCT counselling though only 45% have so far received the full PMTCT training as recommended by Department of Health. Only 22% had had some ongoing training. Only 24% said that they had any technical support. Only 22% of counsellors said that they had a designated counselling supervisor to provide support in their counselling work.

Although 56% of the counsellors interviewed said that they felt valued by their clients the majority did not feel valued by their colleagues or supervisors. Despite this the majority of counsellors said that they would continue in their counselling work for the foreseeable future. Only 5% said that they wanted to stop counselling because they found it too stressful.

This evaluation was carried out one year after the initiation of the programme. The lack of training, particularly ongoing training and technical support, as well as lack of supervision and support of counsellors working for the PMTCT programme could lead to burnout of counsellors or to a decline in the quality of counselling services with time. Furthermore it could be an important contributory factor in the low coverage of zidovudine (ZDV) among HIV positive pregnant women if seropositive women do not receive adequate ongoing counselling to reinforce the importance of adherence.

The Department of Health is encouraging the Regional Health Promotion Centers to increase the training coverage to all counsellors in ANC/MCH services for the implementation period in order to improve the quality of the programme. Development of support structures for counsellors is also important if counsellors are to feel valued and to prevent burnout. In service/ongoing training and supervision of VCT/PMTCT counsellors is essential for counsellors to maintain their high quality of counselling and be aware of current developments in PMTCT.

2. Observation of pre-test, post-test and ongoing counselling session

78 counselling sessions were observed by the research team. This method of evaluating the content and quality of counselling sessions was acceptable to both the counsellors and antenatal attendees. In general both the quality and content of counselling sessions were satisfactory. Some content areas that could be improved were noted. This method of evaluation can help counselling trainers identify content and counselling skills areas that need greater emphasis during the VCT/PMTCT training.

These counselling session observation tools can also be used for periodic assessment of individual counsellors. The feedback to counsellor could also help counsellors to improve their counselling techniques and help them to maintain the quality of their counselling. The observation tools can also be used as part of counselling training and in-service/refresher training.

Interviews with women following VCT in MCH services

180 women were interviewed during the study period. Women were interviewed after their pre-test counselling session and both seropositive and seronegative women were interviewed after ongoing counselling sessions. Most women were satisfied with their counselling experience and 98% of women said that they felt they had been given sufficient information to help them make a decision about HIV testing. The only major criticism was the lack of information about care following VCT. 30% of seropositive women said that they had not received sufficient information about health and social services available to them following VCT.

In this study there was generally poor understanding of the benefits of condom use for HIV prevention in stable sexual relationships. Condom use was, however, seen as being appropriate for use in commercial sex. This may be a reflection of the condom promotion activities in Thailand.

Disclosure of HIV status to husbands/partners was much higher than has been reported elsewhere. 68% of seropositive and 88% of seronegative women had already discussed HIV testing with their partners. HIV testing of partners was also relatively high compared with other settings. 39% of seropositive and 42% of seronegative women's partners had already had an HIV test. HIV testing of partners was, however, largely outside the ANC setting.

There have been reports from other PMTCT programmes of emotional problems for seropositive women who receive VCT in MCH settings. In this study 82% of seropositive women said that they had found it difficult to cope following VCT. 17% of seropositive women said that they had actually contemplated harming themselves or committing suicide. One woman reported that she had actually tried to harm herself. Improving counselling and support services for seropositive pregnant women could be important in helping pregnant women in Thailand cope better following VCT and minimising long-term distress. Other worries following VCT were financial worries (reported by 63% of seropositive women) worries about health (24%), caring for sick partner/relative (13%) and relationship difficulties (7%). Enhanced support and development of a referral network outside the MCH service to, for example, Non-Governmental Organisations (NGOs) and community organisations, could be developed to help women cope following VCT.

Other adverse consequences for seropositive women following have also been reported, such as blame for their HIV infection and abandonment or abuse by sexual partners. In this study although reports of domestic violence were high only one woman said that this had been because of her seropositive status. However, as domestic violence can have such severe consequences for women and their families counsellors could receive training on how to recognise it and be knowledgeable of appropriate referral networks.

2. Introduction

3. Background

In response to the rapidly emerging problem of mother-to-child transmission of HIV, the Ministry of Public Health has recommended and supported routine VCT of women in ANC and avoidance of breast-feeding for HIV-infected women since the early 1990s. A PMTCT programme using short-course zidovudine (AZT/ZDV) regimens was then implemented in two pilot regions, in Region 10[ii] beginning in 1997, and in Region 7[iii],[iv] beginning in 1998. Based on the experience and success of these pilot projects, the Department of Health then recommended and supported an expansion of the programme. A programme of ANC VCT, short-course ZDV (ZDV 2 x 300 mg from 34 weeks of gestation until labour, infant ZDV for 1 week if mother received > 4 weeks ZDV and 6 weeks if mother received < 4 weeks ZDV), and 12 months infant formula for HIV-infected pregnant women in *all* provinces was started in early 2000. A confirmatory test is offered for all women with a HIV positive test result. A second test is offered to women with an HIV negative test result at 32 weeks gestation.

The Thailand PMTCT programme consists of

1) Training of health personnel (VCT, ARV counselling, infant feeding counselling)
2) Integrating Voluntary Counselling and Testing (VCT) , the provision of zidovudine (ZDV/AZT) and infant formula into existing Maternal Child Health (MCH) services.
3) Monitoring
4) Evaluation

The training of health personnel was build up in three phases according to the historical programme requirements. The first training phase covered basic HIV counselling including VCT counselling training. The second phase covered MCH counselling covering MTCT as well as infant feeding counselling. The third phase included antiretroviral (ARV) counselling.

The counselling component of PMTCT programmes was recognised as being a key to the success of the programme. HIV seropositive women can only access and adhere successfully to the ZDV regime, make decisions about minimising the risk of HIV infection from infant feeding and prevent HIV transmission to their sexual partners if they are aware of their HIV status and can understand and cope with the consequences. For women who test seronegative during ANC there are also considerable benefits. If they are at risk from HIV they can make changes in their sexual behaviour to remain negative and can make informed choices about infant feeding and their future fertility. In June to July 2000 the Ministry of Public Health, with support from the World Health Organisation, undertook an evaluation of the VCT services associated with the PMTCT programme in regions 3 and 6.

At the time of the evaluation in the PMTCT programme had been running for 1 year in Region 3 and Region 6.

3. Method

A series of tools were developed and used to evaluate the PMTCT services in Region 3 and Region 6 in Thailand. Nineteen sites were selected, all hospitals (1 MCH hospital, 3 regional hospitals, 3 general hospital and 12 district hospitals). The sites were selected using systematic random sampling using HIV incidence rates in women attending ANC.

The evaluation teams consisted of five people in each region:

- **One researcher/ research assistant from the Bangkok Bureau of Health Promotion, who is in charge of the PMTCT program and responsible for supervision**
- **Two interviewers from the Bangkok Bureau of Health Promotion, Department of Health, these interviewers alternated**
- **One interviewer from counsellor supervision team of each provincial health office of the respective sites visited**
- **One interviewer from counsellor supervision team of the regional health promotion centre of the respective sites visited**

The following series of tools were developed, adapted from the UNAIDS VCT monitoring and evaluation tools[1]. The tools were field tested at 5 sites in Regions 3 and 6, prior to the evaluation and modifications were made following field-testing.

Policy maker

- **Tool 1 Monthly report form.** This self-administered form was filled in at central level with data from ANC on the number of women starting ANC, % HIV tested, % HIV postive, and delivery room on number of women delivering, %ANC, % HIV tested, % HIV positive and % received ARV for regions 3 and 6.

Provider

- **Tool 2** for evaluating the **logistics of VCT and PMTCT in ANC/labour room/post partum ward and well baby clinic**. This was a self-administered questionnaire filled in by Chief of OB/GY (Regional Hospital, Provincial Hospital, District Hospital > 30 beds) or hospital director (District Hospital < 30 beds) and Head nurse of MCH services in all hospitals in the sample. Tool 2 was used at all sited (#=19)
- **Tool 3** for evaluation of **reproductive issues** (#=48)
- **Tool 4** for **counsellor evaluation.** These were Self administered questionnaire filled in by all counsellors working at the selected hospitals during the study period (#=82 available counsellors from each of the 19 selected sites).
- **Tool 5** for evaluation of **pre-test** counselling quality and contents (#=27). These involved research assistants sitting in to observe counselling sessions.
- **Tool 6** for evaluation of **post-test** counselling quality and contents for HIV **positive** pregnant women (#=8). These involved research assistants sitting in to observe counselling sessions.
- **Tool 7** for evaluation of **ongoing/ARV** counselling quality and contents for HIV **positive** pregnant women (attending after 32 weeks) (#=6). These involved research assistants sitting in to observe counselling sessions.
- **Tool 8** for evaluation of **post-test** counselling quality and contents for HIV **negative** pregnant women (#=24). These involved research assistants sitting in to observe counselling sessions.

Client

- **Tool 9** for evaluation of **client satisfaction** and understanding of **pre-test** counselling (#=51)
- **Tool 10** for evaluating HIV **negative** mothers' views and understanding of the contents of post-test and ongoing counselling (#=75)
- **Tool 11** for evaluating HIV **positive** mothers' views and understanding of the contents of post-test and ongoing counselling (#=54)

4. Results

4.1 Suitability of the tools

Tool 1 is used for monitoring the outcomes of the national PMTCT programme. The programme already collected this data.

Following adaptation of the UNAIDS tools, the semi-structured questionnaire tools (**tools 2-4**) were found to be easy to use and the questions unambiguous. Tool 2 was, however, thought to be over-long and will be shortened for routine use.

Tools 5-8, which involved interviewers from regional or provincial counselling supervision team sitting in to observe counselling sessions, were found to be easy to perform and useful for the counsellors. Neither the counsellors nor clients expressed concerns about having counselling sessions observed. This may be in part due to the training of the observers who aimed to be discrete and unobtrusive.

Tool 7, is used for evaluation of ongoing/ARV counselling quality and contents for HIV positive pregnant women. Because HIV positive women may receive several ongoing counselling sessions during their antenatal care not all content areas can be assessed during single observations.

Tools 9-11, which involved interviewing clients following counselling sessions, were also found to be acceptable and feasible. Women were reimbursed travel costs for attending the interviews. Pre-test counselling interviews were exit interviews of consenting women attending services at the day of the evaluation.

Women registered at MCH services who delivered within the last year were invited by letter prior to the post-test counselling/follow-up counselling interviews. In the provincial hospital, however, no women followed the invitation and counsellors had to invite women through phone and the local health centre to agree to the interview. The response at district level was higher.

Tool 12, which examines the costs of VCT in the MCH service, was difficult to use because of the inherent difficulties in collecting costing data. The costing data will be discussed in a separate paper. (Further information following final analysis).

[1] UNAIDS (2001) Tools for evaluating HIV voluntary counselling and testing UNAIDS/00.09E

4.2 Tool 1 Monthly records from ANC clinic and delivery rooms from 1.10.2000 to 1.9.2001

Tool 1 is a self-administered monthly report form. This form is used for data collection at national level.

Figure 1 Flow chart from the ANTENATAL CLINIC region 3 (see table 1)

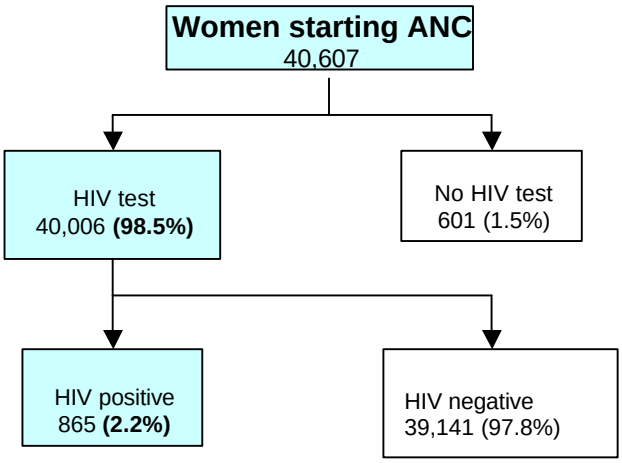


Figure 2 Flow chart from the DELIVERY ROOM region 3 (see table 2 and 3)

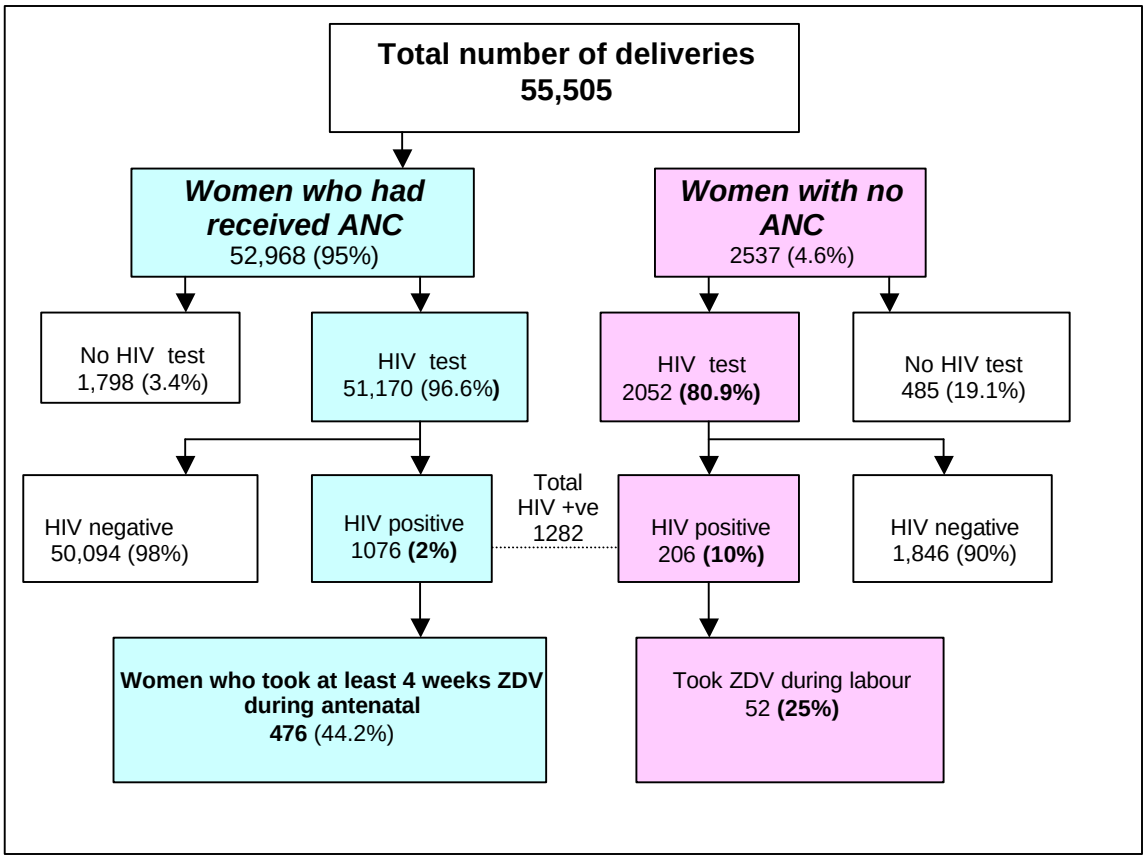


Figure 3 Flow chart from the ANTENATAL CLINIC region 6 (see table 1)

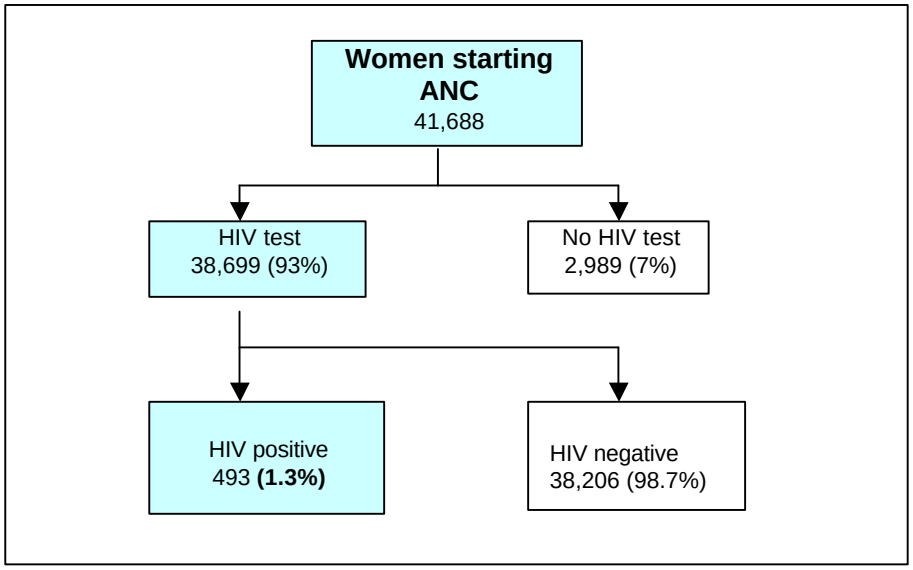
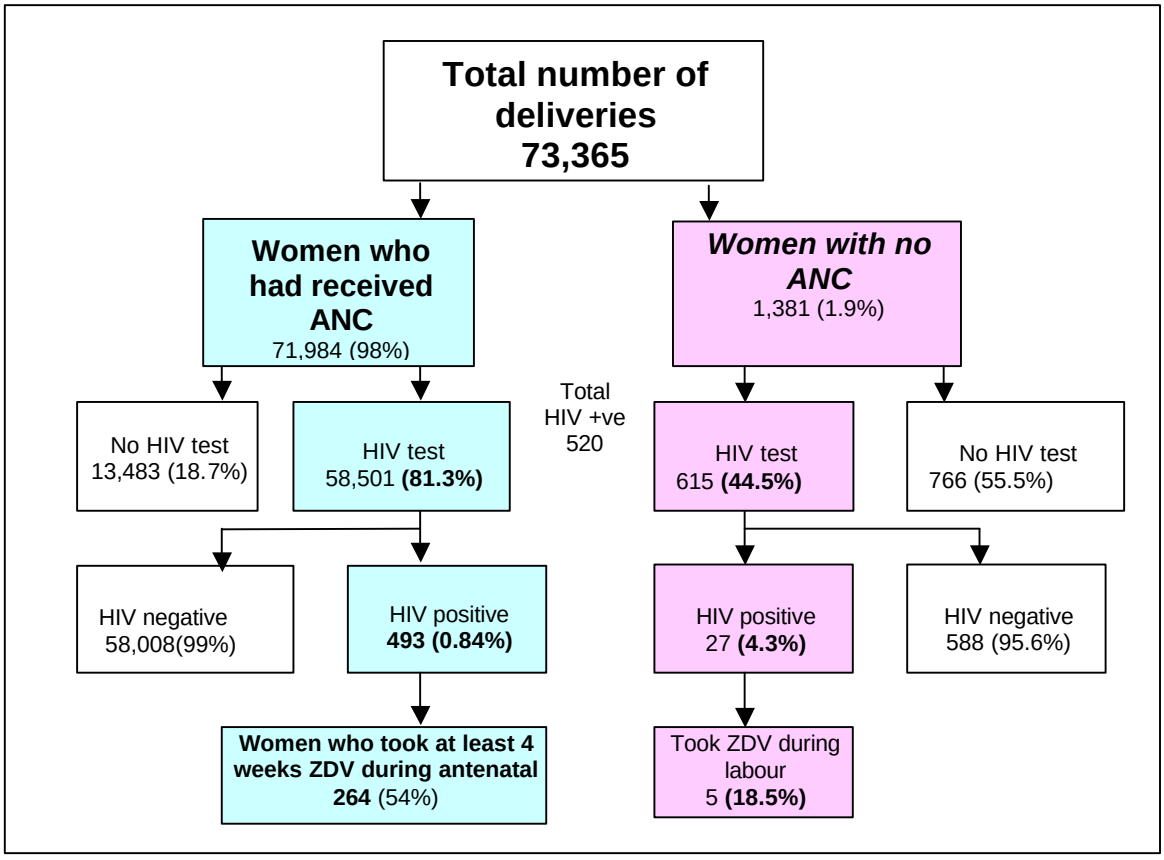


Figure 4 Flow chart from the DELIVERY ROOM region 6 (see tables 2 and 3)



Monthly records from ANC

4. HIV testing and HIV seropositivity rate in ANC

From records collected in the **antenatal clinics** 40,006/40,607 (99%) of women attending ANC in Region 3 and 38,699/41,688 (93%) in Region 6 had an HIV test.

The proportion of women who had been tested who had an HIV positive test result in the antenatal clinics was 865/40,006 (2.2%) in Region 3 compared to 493/38,699 (1.3%) in Region 6 **(Table 1, figure 1 and figure 3)**.

Table 1

FROM ANC CLINICS	Region 3 Number (%)	Region 6 Number (%)
women starting ANC	40,607	41,688
women who did not have HIV test	601 (1)	2,989 (7)
women who had HIV test	40,006 (99)	38,699 (93)
women with HIV+ test	865 (2.2)	493 (1.3)
women with HIV- test	39,141 (97.8)	38,206 (98.7)

5. Monthly records from DELIVERY ROOMS

6.

7. Women with ANC

8. HIV positively rate among women who delivered in the health facility

From data collected in the **delivery facilities**, in **Region 3**, 52,968/55,505(95%) women who delivered had attended ANC. 51,170/52,968 (96.6%) of women who attended ANC had an HIV test. 1,076/51,170 (2%) of those women who received VCT had an HIV-positive test result.

In **Region 6**, 71,984/73,365(98%) of women who delivered had attended ANC. 58,501/71,984 (81.3%) of the women who attended ANC also had an HIV test. 493/58,501 (0.84%) of those women who received VCT had an HIV-positive test result.

The proportion of women with an HIV positive test result at **delivery** was slightly lower than the proportion of women **starting ANC**. (region 3 ANC 2.2%; delivery 2%, region 6 ANC 1.3%; delivery 0.84%). This was probably because of a number of women transferred *in* for delivery from health centres or other districts and provinces and these women are included in the delivery seroprevalence data.

Uptake of ZDV

In **Region 3** 476/1076 (44%) of seropositive women received ZDV. 434/476(91%) reported a good adherence. 153/1076 (14%) women took ZDV for less than 4 weeks, and 401/1076 (37%) did not take any antiretrovirals.

In **Region 6**, 264/493(54%) of seropositive women received ZDV and 251/264(95%) reported good adherence. 75/493 (15%) took ZDV for less than 4 weeks, and 148/493 (30%) did not take any antiretrovirals (**Table 2, figure 2, figure 4**).

Table 2

FROM DELIVERY ROOMS	REGION 3 NUMBER (%)	REGION 6 NUMBER (%)
number of women giving birth	55,505	73,365
women giving birth with ANC	52,968 (95)	71,984 (98)
Women giving birth with ANC who had HIV test	51171 (96.6)	58, 501 (81.3)
women giving birth with ANC with positive HIV test	1,076 (2.) #	493 (0.7) #
women who took only ZDV at least 4 weeks before delivery	476 (44)	264 (54)
women with good adherence*	434 (91)	251 (95)
women with fair adherence**	26 (5.4)	6 (2.3)
women with poor adherence***	16 (3.4)	7 (2.6)
women who took only ZDV for less than 4 weeks before delivery	153 (14)	75 (15)
women who took other antiretroviral with ZDV	2 (0.2)	1 (0)
women who took only other antiretroviral, not ZDV	44 (4)	5 (1)
women who did not take any antiretrovirals during pregnancy	401 (37)	148 (30)
women giving birth with ANC with negative HIV test	50,094 (94.6) #	58,008 (80.6) #
women giving birth with ANC not tested for HIV	1,798 (3.4)	13,483 (18.7)

* Definition of good adherence: woman never forgot to take ZDV or forgot less than 2 doses (not consecutive)
** Definition of fair adherence: woman forgot to take 3-5 doses of ZDV (not consecutive) or forgot to take ZDV within 48 hours.
*** Definition of poor adherence: woman forgot more than 5 doses (not consecutive) or forgot to take ZDV for more than 48 hours.
# The denominator in these cases is the total number of women who gave birth who had ANC – it therefore does not reflect seroprevalence in this group as the denominator includes those who did not have HIV tests. (cf. the flow charts)

Monthly records from ANC clinic and delivery rooms

Women presenting without receiving ANC

Women presenting in labour

2,537/55,505 (4.6%) women from **Region 3** did not receive any antenatal care and presented in labour. Of these 80.9% were tested during labour and delivery. 206/2056 (10%) of those who were tested during labour and delivery had an HIV positive test result and 52/206 (25%) received ZDV during labour.

In **Region 6**, 1,381/73,365 (1.9%) women did not receive any antenatal care. Of these 615/1,381 (44.5%) were tested during labour and delivery. 27/615(4.3%) of those tested had an HIV positive test result and 5/27 (18.5%) received ZDV during labour.

The rates of HIV testing during labour and delivery were very different 615/1,381(44.5%) in region 6 and 2052/2537 (80.9%) in region 3 **(Table 3 and figure 2, figure 4)**.

A greater proportion of seropositive pregnant do not receive antenatal care compared with uninfected women (p=<0.001 for both regions). **(Table 3b)** In **region 3** In region 3, 206/1282 (16%) and in **region 6**, 27/520 (5.2%) of all seropositive pregnant women presented in labour without having had any antenatal care.

Table 3

FROM DELIVERY ROOMS	Region 3 Number (%)	Region 6 Number (%)
Number without ANC	2,537	1,381
Women with positive HIV test	206 (8.1)	27 (1.96)
Women who took only ZDV during labour	52 (25)	5 (18.5)
Women who did not take antiretrovirals during labour	154 (75.0)	22 (1.59)
Women with negative HIV test	1,846 (72.8)	588 (42.6)
Women not tested for HIV	485(19.1)	766 (55.5)

Table 3b Proportion of seropositive women receiving and not receiving antenatal care in regions 3 & 6

	Antenatal care		No antenatal care	
	Total	HIV positive	Total	HIV positive
Region 3	52,968	1076 (2.03)	2537	206 (8.12)
Region 6	71,984	493 (0.68)	1381	27 (1.96)

Monthly records from ANC clinic and delivery rooms Children born to women with HIV

Table 4

FROM DELIVERY ROOMS	Region 3 Number (%)	Region 6 Number (%)
number of live births born to women with positive HIV test	1,419	521
children who received only ZDV at birth	689 (48.6)	258 (50)
children intending to get ZDV for 1 week	281 (40.8)	160 (30.7)
children intending to get ZDV for 6 weeks	324 (47.0)	98 (19)
Children who did not receive ZDV	84 (12.2)	
children who received other antiretroviral with ZDV at birth	1 (0.1)	
children who received only other antiretroviral at birth	21 (1.5)	3 (1)
children who did not start antiretroviral at birth	708 (49.9)	260 (50)

In **Region 3**, 689/1,419 (48.6%) of children born to HIV positive mothers received ZDV at birth.

In **Region 6**, 258/521(50%) of children born to HIV positive mothers received ZDV at birth.

Summary and conclusions Tool 1

Antenatal attendance is high. Data collected in the delivery facilities indicate that in **Region 3**, 52,968/55,505 (95%) of women giving birth had attended ANC and in **Region 6**, 71,984/73,365 (98%) deliveries had attended ANC. However, a disproportionately high number of seropositive women did not receive antenatal care and presented in labour.

Data collected in the **ANC** indicate that the proportion of women starting ANC and who had an HIV test was also very high. 40,006/40,607 (99%) of women in **Region 3** and 38,699/41,688 (93%) in **Region 6** had had an HIV test. Data collected from the delivery facilities showed a lower uptake of VCT in region 6 (Region 3 - 51,170/52,968 (96.6%) of women who attended ANC had an HIV test, region 6 58,501/71,984 (81.3%) of the women who attended ANC also had an HIV test).

Only 476/1,076 (44%) seropositive women who attended ANC took the complete recommended course of ZDV (4 or more weeks ZDV prior to delivery) in Region 3 and only 264/ 493 (54%) in Region 6.

ZDV uptake by infants born to HIV positive women was also relatively low, with only 48.6% of infants from **region 3** and 50% from **region 6** receiving ZDV within the first 48hours of life.

The MOPH aims to increase coverage of ZDV. The reasons for the low coverage are evaluated by tool 2 to tool 11.

4.3 Tool 2 Operational factors and logistics of VCT in ANC/ labour room/post partum ward and well baby clinic

Tool 2, a self administered questionnaire, was sent to the hospital director [2] at all 19 sites. Where necessary, additional information was obtained by interviews with other health personnel.

VCT services offered

9.

10. Pre-test counselling

- All hospitals offer pre-test counselling. 9 offer, either individual or group, 2 only group and 8 only individual pre-test counselling.

11. Post-test counselling

- For women who test **seronegative**, 9 offer both, either individual or group, 3 only group and 7 only individual post-test counselling.

- For women who test **seropositive**, all sites offer individual post-test counselling.

National policy guidelines on HIV pre- and post test counselling

All hospitals stated that they followed the national guidelines on VCT.

Counsellors

The antenatal clinics were all staffed with trained counsellors. All hospitals had at least 1 counsellor working in the ANC/well baby clinic. Only 3 hospitals did not have a trained counsellor in the labour room/post partum ward. There were, however, 7 hospitals where there were no trained counsellor/s working on the post-partum ward.

Counsellor selection

In all hospitals people who were selected for counselling training were already working in the MCH field.

Technical support

8/19 hospitals said that technical support was provided informally by members of the team or other colleagues. 6 hospitals had a counselling network arranged and 3 hospitals have a supervision team or superior who provided technical support. 2 hospitals offered no technical support.

Emotional support

Only 5/19 hospitals had any formal support available to help counsellors with the emotional stresses of counselling. 3 had supervisory teams and 2 counselling networks that provided emotional support for their counsellors. Emotional support for counsellors was though to be provided informally by friends in 8/19, where as 6/19 said that their counsellors had no emotional support available.

Currently the supervision teams of the regional health promotion centres and provincial health offices supervise the district level and are supposed to provide

[2] In district hospitals the hospital director is also the hospital administrator.

ongoing technical support. The supervisory team consists of administrators, trained nurses, counsellors, public health officers and technical officers**.**

Level of services provision and utilisation

During 1.10.99- 30.6.00
Uptake of VCT and the seropositivity rates amongst antenatal attendees from the 19 study sites in region s 3 and 6 was not significantly different from the regional data.

Level of service utilisation from study sites in regions 3 and 6

- 13,784/14,340(96%) received **pre-test counselling** at first ANC visit by ANC staff.
- 11,601/14,532 (80%) of all pregnant women attending ANC for first visit and later visits **returned for post-test counselling**.
- 12,893/14,532 (89%) had an HIV negative test result
- 250/14,532 (1.7%) an HIV positive test result.
- No data were collected on women with indeterminate test result.
- 19/250 (8%) women who were known HIV positive were known to have had abortions.

A relatively low number of HIV positive women had had terminations of pregnancy (TOP). This may be because there are strict regulations, which preclude TOP, except for specific medical indications. Women who had early TOP (before attending from ANC) or those obtaining TOP outside the formal medical setting will not have been included. The rate of HIV positive women who seek TOP may therefore be higher than is evident fromm this study.

HIV testing during labour and the post-natal periods

Some women present in labour without having had counselling or an HIV test during the antenatal period. Hospitals had different approaches to this scenario.

- 12/19 hospitals said that they offer HIV counselling and 13/19 offer HIV testing for women in ***early labour***, who have not previously been tested in the ANC.

- 18/19 hospitals do HIV testing when women are in ***established labour*** (15/19 inform and 3/19 do not inform women)

- 6/19 hospitals said that they would offer test women for HIV during labour without pre-test counselling but would offer post-test counselling to women on the post-natal ward

- 2/19 hospitals would offer HIV testing ***after delivery***

Of the 18 hospitals which test women during labour
15/18 give intra-partum ZDV
15/18 give ZDV syrup to the infant

Confidentiality and privacy

8/19 hospitals stated that they did not have adequate space to provide private post-test counselling sessions.

Disclosure

- 17/19 hospital disclose HIV test results only to the person tested.
- 2/19 hospitals would allow disclosure of HIV result to a woman's husband without her consent.
- 0/19 hospitals would allow disclosure of HIV result to a woman's family without her consent.

Confidentiality

Only 11/19 hospitals had a written policy on confidentiality.

Patient confidentiality can be breached unwittingly if systems are not in place to prevent this. For example:

- 7/19 hospitals have OPD cards that have a visible sign to draw attention of HIV status
- 16/19 do not have secure storage of notes
- 5/16 hospitals which have computerised HIV test results have a system to protect access to this information.

All counsellors have received specific guidance on confidentiality. Only one hospital did not offer guidance on confidentiality to other health workers who have access to HIV test results.

The DOH recommends hospitals to remove visible signs on OPD cards, and ensure secure storage of notes and HIV test results as well as secure access to computerised data.

Referrals and linkages

Most hospitals do not refer seropositive women to other care and support services (**Table 5**). This may reflect a lack of real or perceived need by for referrals, as 17/19 hospitals stated that there were adequate referral services available for seropositive women, within the hospital and 16/19 in the community.

12. Table 5. Referrals from ANC/MCH clinics to other services

	often	sometimes	never
Medicine section	1	4	14
Social services	2	7	10
Other counselling services	0	7	12
NGOs	1	3	15
Family planning services	3	8	8
TB/chest clinic	0	3	16
STI services	0	3	16
Traditional healers	0	1	18
Spiritual/religious groups	2	1	16

HIV testing methods

17/19 hospitals carry out initial HIV testing on site. 9/19 sites send confirmation test to a referral centre. A wide range of different testing schedules are employed. All but 2/19 hospitals are able to provided confirmed HIV test results within 2 weeks.

The most frequently used HIV tests were rapid test and Gel Particle Agglutination (GPA) (**Table 6**).

Table 6. Range of HIV test kits used

Method	# hospitals
ELISA	1
GPA	1
ELISA & GPA	2
Rapid test & ELISA	1
Rapid test & GPA	9
Rapid test & ELISA & GPA	4
GPA & immuno	1

The majority of sites had an elapsed time from HIV test to result of less than 2 weeks (**Table 7**).

13. Table 7 time from taking HIV test to result being available

	First test	Confirmation
Same day	6	2
1-7 days	9	9
1-2 weeks	4	6
>2 weeks		2

11/19 hospitals participate in an external quality control system for HIV testing

Only 5/19 hospitals had ever experienced any shortages in HIV test kits

Opening hours per day/per week

All hospitals had at least one day per week when pre- and post-test counselling and ZDV were provided (**table 8**).

14. Table 8. Frequency of services provided

Day per week that service is provided	Pre-test counselling # =19	Post-test counselling # = 19	ZDV provision # =19
1	9	9	9
2	3	2	3
5	7	8	7

Cost

17/19 hospitals charge antenatal women for HIV testing, which is part of a package checking haemoglobin, VDRL, hepatitis B and haemoglobin electrophoresis for thalassemia. The range of costs are from 70-210[3] Thai baht [4]

However in 13/19 hospitals there are low-income women and women who are covered by health insurance which reimburse the hospital. The percentage of women who are exempt from paying ranges from 0.55 to 30% depending on site).

Drug Supply

[3] HIV testing is offered as part of an antenatal-screening package (including VDRL, hepatitis B, Haemoglobin electrophoresis, and full blood count). The cost quoted is for all these tests. HIV testing is not costed separately. Confirmation of HIV testing is included in this screening package.

[4] ≈ 37.84 Thai baht = 1 US $ in year 2000

All hospitals had adequate supplies of in date ZDV capsules and syrup during the period I.10.99- 30.6.00

Service delivery

The majority of hospitals had developed measures to facilitate the implementation of PMTCT services within their hospital (**Table 9**).

Table 9 Measures introduced to ensure smooth-running of PMTCT service

Measures introduced to ensure smooth-running of PMTCT service	# = 19
Appointed someone to be in charge of the PMTCT programme	17
Ensured there is always someone trained in PMTCT available during clinic hours	18
Sensitise other hospital personnel in PMTCT	19

Problems and challenges identified

- 10/19 hospitals acknowledged that there had been an **increase in workload** since the introduction of the PMTCT programme, but only 2/19 felt that this was a sufficiently important problem to warrant increased numbers of staff (**Table 10**).

- **Lack of training, ongoing training supervision and support** for counsellors were the most commonly noted problems with the PMTCT programme and the majority of hospitals thought that these were important areas that could be improved (**Table 11**).

- 15/19 hospitals thought that **improved educational material** about PMTCT should be developed.

Table 10. Problems encountered with the PMTCT programme

Problems encountered with the PMTCT programme	# = 19
Workload	
Workload problems since introduction of VCT and PMTCT programme	10
Training	
Lack of training	5
Lack of ongoing training	11
Support	
Lack of emotional support	7
Lack of technical support	3
Lack of admin support	6
Lack of supervision	10
Staff loss	
Staff moved to other posts within the hospital	5
Staff left hospital to work elsewhere	2
Administration	
Completing log book	4
Completing monthly report	4

Table 11 Suggestions to improve the PMTCT programme

Suggestions to improve the PMTCT programme	# =19
Staff	
More personnel to cope with the increased workload	2
Training	
Improved counsellor training	12
Improved ongoing training	13
Support	
Improved counsellor support/ form counsellor support group	12
Improved counsellor supervision	15

Summary and conclusions Tool 2

Reviewing the operational aspects of the PMTCT programme revealed a high level of organisational strengths. The focal person in charge of the PMTCT programme had ensured that there was always at least one trained counsellor in the each antenatal site. However, some sites did not have trained counsellors in labour room and/or the post partum clinic. In the majority of sites HIV testing during labour and the post-natal periods was offered, as some women present in labour without having had any antenatal care. VCT training for health staff working on the labour and post-natal wards could therefore be considered. In small hospitals health care staff may work both on the labour ward and on the postnatal ward.

All sites offered pre-test counselling, either as group or individual. All sites offered individual post-test counselling for HIV positive women. In all except two sites HIV test results were disclosed *only* to the woman tested. However it was noted that at some sites confidentiality in MCH services needed strengthening.

The majority of sites charged a fee for antenatal blood screening (including HIV testing). However, in 13/19 sites the cost for HIV testing was covered for all women by social welfare, health card or co-payment.

There was no shortage of ARV supply at any PMTCT sites during the study period. A periodic shortage of HIV tests was noted in some sites.

Few sites actively referred seropositive pregnant women for other medical care or social support. This could either reflect a lack of available support services or a lack of recognition of the needs of seropositive women.

Half of the sites acknowledged that the PMTCT programme had increased workload in the antenatal clinic. However it was felt that improving training, ongoing training supervision and support for counsellors was more important than increasing the number of health workers. Most sites noted that an improved training programme with the development of better patient information material was a priority.

4.4. Tool 3 Reproductive Issues

48 counsellors were interviewed using tool 3 to examine issues related to family planning.

Table 12 Recommended Family planning methods

Family planning method recommended	To all seropositive women	To some women	To no women
Tubal ligation	42	4	2
Hormonal	11	11	26
IUDs	1	2	44
Condoms in addition to other FP method	41	4	2

Tubal ligation was the most commonly recommended method of family planning offered. Tubal ligation was recommended for *all* seropositive women by 42/48 (87%) of counsellors.

Seropositive women were also recommended to use condoms in addition to other methods of family planning (FP) by 41/48 (85%) of counsellors (Table 12).
The DOH does *not*, however, recommend IUD's as a method of FP for HIV positive women.

4.5 Tool 4 Counsellors

82 counsellors from the 19 study sites were interviewed. The interviews were semi-structured and cover areas such as counsellors' attitudes, training, workload and burnout.

15.

This sample represented all counsellors working in the PMTCT programmes in the study sites during the time when the study was being carried out.

Background

The majority of counsellors interviewed (74%) were professional nurses. The others belonged to different cadres of health workers. The majority 66/82 (80%) worked in the antenatal clinic and labour room (table 13).

Table 13 Workplace of counsellors

Place of work	# = 82
ANC/WBC	31
Labour room	32
Labour room & PN ward	3
Counselling clinic	5
Paediatric ward	2
Sanitation section	1
OPD/IPD	2
Total	82

Selection

The majority of health workers doing PMTCT counselling felt comfortable with their work. Only 8/82 (10%) of counsellors felt that they had been pressurised into doing counselling work.

Training

60/82 (73%) of counsellors said that they had had **general HIV counselling training**. 56 (93%) of these rated their counselling training either as very good or good.

40/82 (49%) had had **HIV/MCH training**. 37 (92%) rated this as being very good or good.

37/82 (45%) had had specific training in counselling associated with **PMTCT** (including administration of ZDV). 35 (95%) rated this as being very good or good.

30/82 (37%) of counsellors had attended additional counselling training covering different areas.

36 counsellors mentioned areas where they felt that they required more training (**Table 14**).

Table 14 Further training needs of counsellors

Area of further training	# = 82
HIV and PMTC (including ZDV)	15
Counselling for HIV infection	10
Sexual relationships and family conflict	4
Group counselling	2
Counselling in the ANC	2
Herbal treatment and nutrition for PLHA	2
Pre-marital counselling	1
Total	36

Ongoing Training

18/81 (22%) of counsellors interviewed had had some ongoing training. 17 of those who had thought that it had been useful.

Support and supervision

Only 20/82 (24%) said that they had any technical support. Technical support was provided by the AIDS network, doctors, information from journals and supervisors. Colleagues (31/82 (38%)) most commonly provided emotional support for counsellors.

18/82 (22%) of counsellors said that they had a designated counselling supervisor to provide then with support in their counselling work.

Satisfaction & "Burnout"

HIV and PMTCT counselling is a relatively new duties for health care staff and they are often expected to carry out these tasks in addition to their usual nursing or medical tasks.

Although 56% of counsellors said that they felt their work was valued by clients, the majority felt undervalued by their superiors and colleagues.

Table 15 Counsellor satisfaction

	# (%) answering yes Total = 82		
In your counselling duties, do you feel valued by: Clients Hospital director/chief of section Colleagues	 46 (56%) 19 (23%) 32 (39%)		
Do you receive support from the hospital administration?	**Always** 24 (29%)	Sometimes 51 (62%)	**Never** 4 (5%)
Are you given adequate time to carry out your counselling duties?	18 (22%)	56 (68%)	5 (6%)

Counsellors were asked to say how they felt about various statements. The majority of counsellors agreed with the positive statements and disagreed with the negative statements (**Table 15,16**).

16. Table 16 Counsellor burnout

	always	often	occasionally	never
"I feel emotionally drained by my work as a counsellor in ANC/MCH services"	0	1 (1%)	30 (37%)	49 (60%)
"My work is very stressful"	4 (5%)	5 (6%)	52 (63%)	20 (24%)
"My work is very rewarding"	33 (40%)	32 (39%)	14 (17%)	1 (1%)
"My work environment is very stressful"	2 (2%)	13 (16%)	55 (67%)	11 (13%)
"I learn something new in my work every day"	25 (31%)	33 (40%)	23 (28%)	0
"I feel isolated in my work"	0	3 (4%)	41 (50%)	37 (45%)
"I have problems communicating with my colleagues"	1 (1%)	1 (1%)	50 (61%)	29 (36%)
"I can help my clients"	28 (34%)	40 (49%)	3 (4%)	0
"I have no confidence on my clinical skills"	3 (4%)	2 (2%)	59 (72%)	15 (18%)

Workload

The counsellors had been working in the MTCT/VCT programme between 2 months and 8 years. The mean length of time was 30 months.

There was a wide range of time that nurse/counsellors spent doing counselling. Counsellors spent between 1 and 8 hour counselling per day (mean 1.8 hours) and 1-5 days per week (mean 2.7 days). Counsellors said that they saw 1-30 clients per day (mean 5).

The future

The majority of counsellors 67/82 (81.7%) said that they would go on with their counselling work for the foreseeable future. Only 4 (5%) said that they found the work too stressful and wanted to find a new job. 2 (2.4%) said they wanted to move to another hospital.

Summary and conclusions Tool 4

82 counsellors from the 19 sites were interviewed in depth about their counselling roles. 74% of the counsellors working in the PMTCT programme were professional nurses. The majority said that they felt comfortable with PMTCT counselling though only 45% have so far received the full PMTCT training as recommended by DOH. Only 22% had had some ongoing training. Only 24% said that they had any technical support. Only 22% of counsellors said that they had a designated counselling supervisor to provide then with support in their counselling work.

Although 56% of the counsellors interviewed said that they felt valued by their clients the majority did not feel valued by their colleagues or supervisors. Despite this the majority of counsellors said that they would continue in their counselling work for the foreseeable future. Only 5% said that they wanted to stop counselling because they found it too stressful.

This evaluation was carried out one year after the initiation of the programme. The lack of training, particularly ongoing training and technical support, as well as lack of supervision and support of counsellors working for the PMTCT programme could lead to burnout of counsellors or to a decline in the quality of counselling services with time. Furthermore it could be an important contributory factor in the low coverage of zidovudine (ZDV) among HIV positive pregnant women if seropositive women do not receive adequate ongoing counselling to reinforce the importance of adherence. The Department of Health is encouraging the Regional Health Promotion

Centres to increase the training coverage to all counsellors in ANC/MCH services for the implementation period in order to improve the quality of the programme.

4.6 Tool 5 PRE TEST COUNSELLING content

40 observations were made of pre-test counselling sessions, this included 13 group counselling and 27 individual counselling sessions.

The research assistant observed the sessions and completed a checklist of **content areas** for each session. **Counselling skills** were also observed.

The individual counselling sessions lasted between 5-30 minutes (mean 16 minutes) and the group counselling sessions between 10-60 minutes (mean 21 minutes).

1 hospital used video, 11 flip charts or posters and 10 had patient leaflets available to provide additional information on PMTCT.

Content areas

27 individual counselling sessions and 13 group counselling were observed and the following areas were covered:

Table 17 Counselling contents during pre test counselling

During the session have the following occurred?	Group sessio # (%) yes total=13	Individual sessions # (%) yes total = 27
HIV transmission &risk behaviour	13 (100%)	26 (96%)
Safer sex	7 (54%)	20 (74%)
Misconceptions corrected[5]	10 (77%)	15 (55%)
Information concerning the HIV test given[6]	13 (100%)	16 (59%)
Information about HIV in pregnancy and the risk of MTCT	13 (100%)	19 (70%)
Benefits of knowing her status and interventions available if the result is positive[7]	12 (92%)	14 (52%)
Implications of a +ve result for her baby	8 (61%)	7 (26%)
Implications of a +ve result for future children	3 (23%)	6 (22%)
Implications of a +ve result for decisions about infant feeding	7 (54%)	7 (26%)
Implications of a +ve result for her relationship with baby's fat	5 (38%)	5 (18%)
Implications and benefits of sharing a +ve result with baby's fa	4 (31%)	4 (15%)
Discussions around the benefits of testing together baby's fath	4 (31%)	8 (30%)
Explaining that testing is voluntary	11 (85%)	23 (85%)
Understanding checked for	10 (77%)	13 (48%)
Adequate time for questions and clarifications	11 (85%)	20 (74%)

The majority of sessions included basic information on HIV transmission and prevention and PMTCT. However there was less coverage of the benefits of VCT and in particular the benefits of partner testing (**Table 17**). In the individual counselling sessions the implications of an HIV positive test result for the baby and the benefits of sharing HIV test results were not covered in the majority of pre-test counselling sessions.

[5] e.g. sharing toilet, bathroom, dishes, etc does not transmit HIV
[6] e.g. process of testing, meaning of possible test results, window period
[7] including making it clear that ARV therapy for PMTCT cannot be given to women whose status is not known

Table 18 Counselling skills

Function	Skills	Group # (%) yes total=13	Individual # (%) yes total=27
Interpersonal relationship	Greets clients	10 (77%)	15 (56%)
	Engages client in conversation	10 (77%)	17 (63%)
Group counselling	Gives information in clear and simple terms	11 (85%)	10 (37%)
	Responds to patients questions	11 (85%)	7 (26%)
	Has up-to-date knowledge about HIV	5 (38%)	4 (15%)
	Repeats and reinforces important information	9 (69%)	5(18%)
	Allows all members to participate	9 (69%)	5 (18%)
	Seeks clarification about information given/discussed	8 (61%)	3 (11%)
	Directs discussion appropriately	11 (85%)	5 (18%)
	Checks for understanding/ misunderstanding	9 (69%)	4 (15%)
	Summarises main issues discussed	8 (61%)	3 (11%)
Individual counselling	Uses appropriate balance of open and closed questions	5 (38%)	24 (89%)
	Uses silence well to allow for self-expression (does not interrupt client	1 (8%)	17 (63%)

	expression (does not interrupt client		
	Avoids premature conclusions	2 (15%)	13 (48%)
	Gives client time to absorb information and to respond	5 (38%)	17 (63%)
	Summarises main issues discussed	3 (23%)	14 (52%)

Summary and conclusions Tool 5

In general there was high coverage of the majority of content areas in the pre-test counselling sessions. The areas that were adequately covered included, HIV transmission and risk behaviours, voluntary nature of HIV testing, vertical HIV transmission. Time for questions and clarifications was also adequate. The group sessions, however, provided greater coverage of most content areas, except for the discussion on safer sex. The differences were not however statistically significant. Areas that were less well covered included the implications of an HIV positive test result for the child and family, the implications and benefits of sharing HIV test result with the father and partner testing. These results could be helpful as feedback for the counsellors and counsellor trainers so that the content of future counselling sessions could be enhanced. It also indicated the potential for providing the majority of the more factual information in group counselling sessions with an additional shorter individual counselling session where women could discussion more sensitive issues such as safer sex.

The feedback of individual counsellor's skills (**Table 18**) could also help counsellors to improve their counselling techniques. Routine appraisal of counselling quality and content could be considered to ensure the continuation of the delivery of a high standard of counselling.

4.7 Tool 6 POST TEST COUNSELLING contents for HIV POSITIVE pregnant women

8 observations were made of **post-test counselling** sessions for women who received **seropositive** results.

These were all individual counselling sessions. They lasted between 15-90 minutes, with a mean of 44 minutes.

Video was not used. 3 women received information leaflets to augment the information they received in their post-test counselling session

The women were between 9-34 weeks gestation, mean 20 weeks.

Content of post-test counselling sessions

8 individual counselling sessions were observed and the following areas were covered:

Table 19 Content of post-test counselling sessions

During the session have the following occurred?	# (%) yes total = 8
Results given simply and clearly	8 (100%)
Time allowed for results to sink in	7 (88%)
Checking for understanding	8 (100%)
Discussion of the meaning of the result for the client	8 (100%)
Discussion of the benefits and risks of sharing information about HIV st	7 (88%)
Dealing with immediate emotional reactions	7 (88%)
Checking that adequate immediate support is available	7 (100%)
Discussion about follow up care	7 (100%)
Discussion about ARVs for PMTCT	8 (100%)
Discussion about infant feeding options	6 (75%)
Discussion about safer sex	5 (63%)
Options and resources identified	8 (100%)
Immediate plans, interventions and reactions reviewed	6 (75%)
Follow-up visits for ARVs and infant feeding counselling arranged	6 (75%)

Counselling skills

Table 20 counselling skills during post test counselling sessions

Function	Skills	# (%) yes total = 27
Interpersonal relationship	• Greets clients • Engages client in conversation	6 (75%) 5 (63%)
Individual counselling	• Uses appropriate balance of open and closed questions • Uses silence well to allow for self-expression (does not interrupt client • Avoids premature conclusions • Gives client time to absorb information and to respond • Summarises main issues discussed	8 (100%) 8 (100%) 6 (75%) 7 (88%) 5 (63%)

Summary and conclusions Tool 6

The post-test observation tool was easy to use and acceptable to both counsellors and clients. Post-test counselling contents and counselling skills for HIV positive women was considered as adequate (**Tables 19 &20**).

4.8 Tool 7 Follow up counselling content for HIV positive pregnant women for MTCT programme attending after 32 weeks

Women who test **seropositive** during their antenatal period will need to receive ongoing counselling during their antenatal and post natal care to ensure that they have adequate support to cope following testing, receive help to adhere with the ARV regimen and can consider infant feeding options. They can also consider disclosure to their husband/partner or to a close family member or friend. Safer sex choices and barriers to safer sex can also be discussed. 6 observations were made of follow up counselling sessions for women who received seropositive results **after 32 weeks gestation.** All the follow up counselling sessions observed were individual counselling sessions.

Counselling sessions lasted 5-30 minutes with a mean of 20 minutes.

Video was not used in any of the sessions. 3 women received leaflets about PMTCT.

Content of follow-up/ongoing counselling sessions

6 individual counselling sessions were observed and the following areas were covered:

Table 21 Content of follow-up/ongoing counselling sessions

During the session have the following occurred?	# (%) yes total = 6
17. Has prevention of HIV transmission been discussed?	
Information about safer sex and prevention of HIV and STIs	4 (67%)
Discussion about discordancy	2 (33%)
Discussion of a personal risk reduction plan	1 (17%)
Discussion about disclosure of status to partner	2 (33%)
Discussion of partner being offered HIV testing	1 (17%)
Have specific questions about planning for the future been covered?	
Information about care of the child [8]	2 (33%)
Follow-up plans made and referrals where necessary	2 (33%)
Have specific questions about MTCT and ARV treatment been covered?	
Previous ARV use	5 (83%)
Not a cure	3 (50%)
Need to attend maternity services	4 (67%)
Decision to take ZDV in voluntary	3 (50%)
Need to take ZDV as prescribed	4 (67%)
The regimen explained	3 (50%)
ANC dose and labour dose	3 (50%)
What to do if the woman forgets to take ZDV	3 (50%)
The need to take medicines continually according to the regime	3 (50%)
The possible side effects and when to seek medical help	4 (67%)
Other medicines being taken	2 (33%)
Understanding checked for	3 (50%)

[8] including nutritional advice and seeking early treatment for illnesses

Counselling skills

Table 22 Counselling skills of follow-up/ongoing counselling sessions

Function	Skills	# (%) yes total = 6
Interpersonal relationship	• Greets clients • Engages client in conversation	4 (67%) 4 (67%)
Individual counselling	• Uses appropriate balance of open and closed questions • Uses silence well to allow for self-expression (does not interrupt client • Avoids premature conclusions • Gives client time to absorb information and to respond • Summarizes main issues discussed	5 (83%) 3 (50%) 1 (17%) 3 (50%) 1 (17%)

Summary and conclusions Tool 7

This tool was found to be easy to use and acceptable to both counsellors and clients. In this study only a small number of counselling sessions were observed. Furthermore because seropositive women may attend several ongoing counselling sessions content areas may have been covered in previous sessions so it is difficult to assess the adequacy of the content areas in a single session observation.

4.9 Tool 8 Post-test counselling content for HIV negative pregnant women in MTCT programme

24 observations were made of **post-test counselling** sessions for women who received **seronegative** results.

7 were group and 17 individual counselling sessions. They lasted between 5-75 minutes, with a mean of 14 minutes.

Video was used during 1 session. 4 women received information leaflets to augment the information they received in their post-test counselling session

Content of post-test counselling sessions

24 counselling sessions were observed and the following areas were covered:

Table 22a Content of post-test counselling sessions for HIV negative women

During the session have the following occurred	# (%) yes total = 24
Safer sex information	22 (92%)
Discussion about discordancy	19 (79%)
Discussion of the benefits of partner testing	14 (58%)
Offered second test prior to delivery	9 (38%)

Counselling skills

No data were collected on counselling skills of post-test counselling session for HIV negative women.

Summary and conclusions Tool 8

Adequate information was given on safer sex and discordance in the majority of sites. Partner testing and second test prior to delivery in high-risk groups needed reinforcement.

4.10 Tool 9 Client satisfaction and understanding following pre-test counselling

51 exit interviews were conducted with pregnant women following **pre-test counselling.** Women who visited ANC on the day of the evaluation and gave consent were interviewed.

23 women have received group and 28 individual pre-test counselling. At the time of interview the women had not received their HIV test result.

Demographic information

The women interviewed ages ranged from 14-39 with a mean of 25 years. The majority of women 25/51 (49%) had at least primary school education. 50/51 (98%) were married. 37/51 (72%) had a family income of less than baht 10,000 per month (**Table 23**).

18. Table 23 Demographic data of women exiting pre-test counselling

	# (%) total=51
Education	
Less than primary	2 (4%)
Primary	23 (45%)
Junior high	16 (31%)
High school	4 (8%)
Basic vocational	3 (6%)
College or higher	2 (4%)
None	1 (2%)
Marital status	
Single	1 (2%)
Married	50 (98%)
Total family income	
None	4 (8%)
< 2,500	14 (28%)
2,500 – 4,999	9 (18%)
19. 5,000 – 9.999	10 (20%)
10,000 – 14,999	9 (18%)
> 15,000	5 (10%)

20. Source of information on PMTCT

None of the women interviewed said that they had seen a video about PMTCT. 27 (53%) had seen posters and 8 (16%) leaflets on PMTCT. 39 (77%) of women had had some information on PMTCT before they attended the antenatal clinic. 20/51 (40%) of women had had PMTCT information from media (**Table 24**).

Table 24 Source of information on PMTCT

21. Source of information on PMTCT	**# (%) total=51**
Health centre	6 (12%)
Community hospital	10 (20%)

General hospital	4 (8%)
Private clinic	9 (2%)
Volunteer	1 (2%)
Media	20 (40%)
School/study site	7 (14%)

Satisfaction with HIV counselling

40/51 women discussed having an HIV test, 27/51 discussed PMTCT and 11/51 discussed other issues about HIV and HIV transmission.

45/51 (88%) women interviewed said that they had been given **adequate information** to make a decision about HIV testing. 43/51 (84%) said that they had **adequate time** with the counsellor to get all the information you wanted to know about HIV testing. However, 16 (31%) of women felt that there were additional questions they had wanted to ask. 8 women could not understand things that they had been told, 2 said that thing were not clear, 2 were afraid of the doctor, 2 were too ashamed and 2 did not dare ask questions.

6/51 (12%) of women were not satisfied with their counsellor and would like to see a *different* counsellor if they needed further counselling. However, 50/51 (98%) of women said that they would recommend HIV testing to a pregnant friend or relative (**Table 25**).

Table 25 Recommending HIV testing to others

Reasons given for recommending HIV testing to pregnant friend/family member	# (%) total = 51
To know whether one is infected or not	26 (52%)
If she knows she is +ve she can prevent MTCT	8 (16%)
Knowing status is of benefit to both mother and child	6 (12%)
To stop the spread of HIV	5 (10%)
If +ve to have termination of pregnancy	1 (2%)

However, 16/51 (34%) of women said that they would **not** recommend HIV testing to someone who was not pregnant. Of the 34/51 who said that they would recommend HIV testing, 4 said that they would recommend testing to a husband/boyfriend, 10 to a friend and 20 to a family member.

20/51 (61%) said that they had already recommended HIV testing, 3 to their boyfriend/husband, 10 to friends and 7 to family members.

Understanding of basic HIV/PMTCT counselling contents

50/51 (98%) and 51/51 (100%) understood that HIV was transmitted through heterosexual contacts but 10/51 (20%) stated that a condom could not prevent HIV transmission. Understanding of HIV transmission from mother to child was adequate (**Table 26**) but on 30/51 (59%) of women knew that there were medicines to prevent vertical HIV transmission.

Table 26 Understanding of basic counselling contents

	Yes # (%)	No # (%)	Not sure/don't know
HIV transmission HIV transmitted when M has sex with +ve F	50 (98%)	0	1 (2%)
HIV transmitted when F has sex with +ve M	51 (100%)		
Condom use during sex with an +ve partner can prevent HIV transmission	23 (45%) (always) 18 (35%) (not perfect)	10 (20%)	0
MTCT F can infect their babies during pregnancy & labour	51 (100%)		
F can infect their babies through breastfeeding	46 (90%)	1 (2%)	4 (8%)
Are there medicines available to PMTCT?	30 (59%)	11 (22%)	10 920%)
Why are you offered an HIV test when you are pregnant? To find out my HIV status To receive medicines to prevent my baby being HIV +ve To receive formula to prevent my baby being be HIV +ve To discontinue pregnancy if I am HIV +ve I do no know	 24 (47%) 19 (37%) 4 (8%) 0 2 (4%)		

Consent

42/51 women said that they had signed a consent form for HIV testing. Only 1/51 women said that she did not want to know her HIV test result and that she would not return to collect the result.

Disclosure and partner testing

32/50 (63%) of those women who had a husband/partner said that they had discussed HIV testing with them. 18/50 (35%) said that their partners had already had an HIV test.

Summary and conclusions Tool 9

51 pregnant women were interviewed after their pre-test counselling session. Most women had some information before attending ANC, mostly through media. 88% said that they had been given enough information to make a decision about HIV testing. Although the majority of women interviewed were satisfied with the counselling and counsellor interaction, 12% said that they would prefer to see a different counsellor. 98% said that they would recommend HIV testing to a pregnant friend or relative but 34% said that they would not recommend VCT to someone if they were not pregnant. Only 4 women said that they would recommend VCT to a husband/boyfriend.

4.11 Tool 10 HIV *negative* mothers view and understanding of contents in HIV post-test counselling and ongoing counselling

75 interviews with HIV negative pregnant women following **post-test/ongoing counselling 1 – 12 months after delivery.**

Demographic information

The women interviewed ages ranged from 16-42 with a mean of 26.6 years. 45/75 (60%) of women had only primary school education or less. All women were married. 64/75 (85%) had less than Baht 10,000 income per month (**Table 27**).

Table 27 Demographic data of HIV negative mothers

Demographic information	**# (%) total=75**
Education	
Less than primary	1 (1%)
Primary	44 (59%)
Junior high	15 (20%)
High school	6 (8%)
Basic vocational	3 (4%)
College or higher	2 (3%)
None	4 (5%)
Marital status	
Single	0
Married	75 (100%)
Total family income	
None	0
< 2,500	19 (25%)
2,500 – 4,999	20 (27%)
22. 5,000 – 9.999	25 (33%)
10,000 – 14,999	8 (11%)
> 15,000	3 (4%)

23. Source of information on PMTCT

46/75 (61%) of women had had some information on PMTCT before they attended the antenatal clinic (**Table 28**).

Table 28 source of information on PMTCT

24. Source of information on PMTCT	**# (%) total=75**
Health centre	13 (17%)
Community hospital	14 (19%)
General hospital	6 (8%)
Regional hospital	7 (9%)
Volunteer	1 (1%)
Media	27 (36%)

School/study site	7 (9%)

HIV testing

60/75 (80%) of women interviewed said that they had first learned about their HIV test result during this current pregnancy. 11/75 (15%) said that they had had an HIV test before the current pregnancy. 4 (5%) women said that they did not know their test result (despite having being tested during the current pregnancy).

Of the 71 women who knew their HIV test result, 5 had received their results on the same day, 31 in less than 1 week, 18 in 1-2 weeks and 16 after more than 2 weeks.

Satisfaction with HIV counselling

40/75 (69%) of women said that they had been able to see the same counsellor /nurse/doctor for both pre- and post-test counselling.

62/75 (83%) women interviewed said that they had been given **adequate information** to make a decision about HIV testing. 5 women said that they needed more time, 6 were unsure and 2 women said that they had not had any pre-test counselling. 65/75 (87%) of women said that they had had adequate information to understand what their test results meant and 61/75(81%) said that they had had adequate information on MTCT and PMTCT.

Only 2 women said that they felt they were not able to ask their counsellor/doctor questions about HIV and PMTCT. I said that she was afraid and 1 said that what the doctor said had not been clear.

Only 5/75 (7%) women said that they were not satisfied with their counsellor and would like to see a *different* counsellor.

70/75 (93%) of women said that they would recommend HIV testing to a pregnant friend or relative (**Table 29**).

Table 29 Recommending HIV testing to others

Reasons given for recommending HIV testing to pregnant friend/family member	# (%)
To know whether one is infected or not	34 (49%)
If she knows she is +ve she can prevent MTCT	15 (21%)
Knowing status is of benefit to both mother and child	7 (10%)
To stop the spread of HIV	6 (9%)
If +ve to know how to behave	5 (7%)

However, 16/75 (21%) of women said that they would **not** recommend HIV testing to someone who was not pregnant. Of the 57/75 (76%) of women who said that they would recommend HIV testing, 15/75 (26%) said that they would recommend testing to a husband/boyfriend, 21/75 (37%) to a friend and 19/75 (33%) to a family member, and 1 to men who regularly visits night clubs/ karaoke bars.

41/75 (55%) said that they had already recommended HIV testing, 3 to their boyfriend/husband, 26 to friends and 10 to family members.

Understanding of basic HIV/PMTCT counselling contents

74/75 (99%) and 75/75 (100%) understood that HIV was transmitted through heterosexual contacts but 34/75 (45%) stated that a condom could not prevent HIV

transmission. Understanding of HIV transmission from mother to child was adequate (**Table 30**) but on 33/75 (44%) of women knew that there were medicines for PMTCT.

Table 30 Understanding of basic counselling contents

	Yes # (%)	No # (%)	Not sure/don't know
HIV transmission HIV transmitted when M has sex with +ve F	74 (99%)	0	1 (1%)
HIV transmitted when F has sex with +ve M	75 (100%)		
Condom use during sex with an +ve partner can prevent HIV transmission	33 (44%) (always) 8 (10%) (not perfect)	34 (45%)	0
MTCT F can infect their babies during pregnancy & labour	71 (95%)	4 (5%)	
F can infect their babies through breastfeeding	69 (92%) 1 (1%) (not always)	5 (7%)	
Are there medicines available to PMTCT?	33 (44%)	27 (36%)	15 (20%)
Why are you offered an HIV test when you are pregnant? To find out my HIV status To receive medicines to prevent my baby being HIV +ve To receive formula to prevent my baby being be HIV +ve To discontinue pregnancy if I am HIV +ve I do no know	 40 (53%) 15 (20%) 0 4 (5%) 2 (3%)		

Consent

44/75 (59%) of women said that they had signed a consent form for HIV testing. The MOPH policy is to recommend women to sign consent forms for HIV testing.

Disclosure and partner testing

66/75 (88%) of women interviewed said that they had discussed HIV testing with them. 42/75 (56%) said that their partners had already had an HIV test.

Future pregnancies and family planning

24/75 (32%) of women said that they were planning to have another baby. All said that they would agree to HIV testing again during their next pregnancy.

63/75 (84%) of women had re-started sexual relations following delivery. Only 3/63 (5%) of women used condoms with their partner every time they had sex (**Table 31**).

Table 31 Family planning method used

Family planning method used	# (%) (total 65)
Tubal ligation	19 (29%)
OCP	16 (25%)
Injection	22 (34%)
Norplant	2 (3%)
IUD	1 (1.5%)
Condom	2 (3%)
Natural	3 (5%)

Infant feeding

Table 32 Infant-feeding methods

Infant feeding methods	# (%) total=75
Breast feeding	43 (57%)
Mixed feeding	21 (28%)

Formula feeding	10 (13%)
Baby died	1 (1%)

Summary and conclusions Tool 10

75 HIV negative pregnant women were interviewed.

Most women had some information about HIV/PMTCT before attending ANC, mostly through the media. The majority of women interviewed were satisfied with information, and counsellor interaction and 69% had been able to see the same counsellor at pre- and post-test counselling. There was, however, some room for improvement. Many of the women appeared to be unclear about HIV prevention. There was poor understanding benefit of HIV testing, HIV transmission, and condom use for preventing HIV transmission. Only 44% of HIV negative mothers knew about the availability of medicines for PMTCT. The proportion of women having discussed HIV testing with their partner was high and 56% of women said that their partners had had an HIV test though not usually at the ANC.

The majority of women were breastfeeding or mixed feeding. Only 13% of HIV negative women were only using formula feeding.

Awareness of the possible benefits of use condoms in marriage and relationships other than commercial sex is low in this survey of HIV tested negative pregnant women.

4.12 Tool 11 HIV *positive* mothers view and understanding of contents in HIV post-test counselling and ongoing counselling

54 interviews with HIV positive pregnant women following **post-test/ongoing counselling 1 – 12 months after delivery**

Demographic information

The women interviewed ages ranged from 18-43 with a mean of 26.5 years. 37/54 (69%) of women had only primary school education or less. The majority were married.
51/54 (94%) had an income less than 10,000 Baht per month (**Table 33**).

Table 33 Demographic data of HIV negative mothers

	# (%) total 54
Education	
Less than primary	4 (7%)
Primary	33 (61%)
Junior high	11 (20%)
High school	1 (2%)
Basic vocational	1 (2%)
College or higher	2 (4%)
None	2 (4%)
Marital status	
Single	11 (18.5%)
Married	44 (81.5%)
Total family income	
None	2 (4%)
< 2,500	23 (43%)
2,500 – 4,999	19 (35%)
25. 5,000 – 9.999	7 (13%)
10,000 – 14,999	2 (3.7%)
> 15,000	0

26. Source of information on PMTCT

22/54 (41%) of women had had some information on PMTCT before they attended the antenatal clinic, most from the community hospital (**Table 34**).

Table 34 Source of information on PMTCT

27. Source of information on PMTCT	**# (%) total=54**
Health centre	6 (11%)
Community hospital	16 (30%)
General hospital	7 (13%)
Regional hospital	12 (22%)
Volunteer	0
Media	12 (22%)
School/study site	0

HIV testing

49/54 (91%) of women interviewed said that they had first learned about their HIV test result during this current pregnancy. 4/54 (7%) said that they had had an HIV test before the current pregnancy. 1 woman said that she had had her HIV test after delivery.

5 had received their results on the same day, 20 in less than 1 week, 23 in 1-2 weeks and 6 after more than 2 weeks.

Satisfaction with HIV counselling

42/54 (82%) of women said that they had been able to see the same counsellor /nurse/doctor for both pre- and post-test counselling.

47/54 (87%) of women interviewed said that they had been given adequate information to make a decision about HIV testing. 3 women said that they needed more information and 3 were unsure. 52/54 (96%) of women said that they had had adequate information to understand what their test results meant. Only 38/54 (70%) said that they had received sufficient information on health and social services available to them

51/54 (94%) of women said that they thought that the room where they received counselling was a satisfactory space for private discussion. 46/54 (85%) felt that information about their HIV test would be kept private, 3 were worried that it would not and 3 were unsure.

Only 1/54 (2%) of women said that they were not satisfied with their counsellor and would like to see a *different* counsellor.

53/54 (98%) of women felt that they had made the right decision to have an HIV test. However, only 45/54 (83%) of women said that they would recommend HIV testing to a pregnant friend or relative. The most common reason given for recommending HIV testing was so that she would know whether she was infected or not. Only 5 women cited PMTCT as the main reason (**Table 35**).

Table 35 Recommending HIV testing to others

Reasons given for recommending HIV testing to pregnant friend/family member	# (%) Total 45
To know whether one is infected or not	30 (67%)
If she knows she is +ve she can prevent MTCT	5 (11%)
Knowing status is of benefit to both mother and child	3 (7%)
To stop the spread of HIV	2 (4%)
If +ve to know how to behave	5 (11%)

18/54 (33%) of women said that they would not recommend HIV testing to someone who was not pregnant. Of the 36/54 (67%) of women who said that they would recommend HIV testing, only 1/36 (3%) said that she would recommend testing to a husband/boyfriend, 17/36 (47%) to a friend and 17/36 (47%) to a family member.

25/54 (46%) said that they had already recommended HIV testing, 2 to their boyfriend /husband, 13 to friends and 8 to family members.

Understanding of basic HIV/PMTCT counselling contents

Table 36 Understanding of basic counselling contents

	Yes # (%)	No # (%)	Not sure/don't know
HIV transmission HIV transmitted when M has sex with +ve F	54 (100%)	0	0
HIV transmitted when F has sex with +ve M	53 (98%)	0	1 (2%)
Condom use during sex with an +ve partner can prevent HIV transmission	26 (48%) (always) 4 (7%) (not perfect)	24 (44%)	0
MTCT F can infect their babies during pregnancy & labour	46 (85%)	8 (15%)	
F can infect their babies through breastfeeding	52 (96%)	2 (4%)	
Are there medicines available to PMTCT?	48 (89%)	2 (4%)	4 (8%)
Why are you offered an HIV test when you are pregnant? To find out my HIV status To receive medicines to prevent my baby being HIV +ve To receive formula to prevent my baby being be HIV +ve To discontinue pregnancy if I am HIV +ve I do no know	 28 (52%) 13 (24%) 5 (9%) 2 (4%) 2 (4%)		

Consent

48/54 (89%) of women said that they had signed a consent form for HIV testing according to the national policy recommendation.

Confidentiality

10/54 (18.5%) of women said that people had found out that they were HIV positive without then telling them. 5 women said that their parents and 5 said neighbours had somehow found out about their seropositive status. None of the women interviewed thought that this unwanted disclosure had been made by health care staff. 9 women thought that either their boyfriend/husband or a partner had told others about her status. One woman said that people must know she was HIV positive because she did not have a boyfriend/husband.

It has been proposed that seropositive women participating in PMTCT interventions will be identified as having HIV because they are taking ARVs or formula feeding their babies. 13/54 (24%) of women though they could be identified as having HIV because they took ZDV and 17/54 (31.5%) because they were formula feeding.

Disclosure and partner testing

37/54 (68.5%) of women said that they had discussed HIV testing with their partner /husband. 21/54 (39%) of women said that their husbands had also been tested.

Domestic violence

8/54 (15%) had experienced at least one episode of physical violence from their partner /husband in the preceding 5 years. However, only one woman said that was because of her HIV infection.

PMTCT

ZDV

47/54 (87%) women took ZDV for PMTCT during their pregnancy. Of the 7 women who had not 6 wished that they had been able to.

28. Termination of pregnancy (TOP)
28/54 (52%) of women said that they wanted to terminate their pregnancy after they found out they were HIV positive.

HIV testing of infants

41/54 women had already taken their babies for HIV testing and 12 women were planning to do so. Only one woman said that she was unsure if she would have her baby tested.

Infant feeding

The majority of seropositive women had chose to use infant formula to feed their babies (**Table 37**).

Table 37 Infant-feeding methods

Infant feeding methods	# (%) total 54
Breast feeding	1 (2%)
Mixed feeding	1 (2%)
Formula feeding	52 (96%)

The women who choose breastfeeding and mixed feeding used these methods because they feared stigma associated with formula feeding and HIV infection.

Future pregnancies and family planning

5/54 (9%) of the seropositive women interviewed said that they were planning to have another baby. One woman was unsure.

39/54 (72%) of women had re-started sexual relations following delivery. 46/54 women were using a method of family planning at the time of the interview (**Table 38**).

Table 38 Family planning method used

Family planning method used	# (%) (total 46)
Tubal ligation	22 (47.8)
OCP	7 (15%)
Injection	13 (28%)
Norplant	2 (4%)
IUD	0
Condom only*	2 (4%)
Natural	0

See below for condom in addition to other FP method

Referral for HIV health assessment and management

23/54 seropositive women had been seen for a check up for their own health following delivery (**Table 39**).

Table 39 HIV/AIDS clinical care and support

	# (%) total = 54
Have you had a medical check up following your delivery	23 (43%)
Medical advice	
Regular health check ups	19
Advice about PCP prophylaxis	15
Advice about symptoms of tuberculosis (TB)	13
Advice about symptoms of OIs	12

Referral to support group	8 (15%)

Problems

The most pressing problems for seropositive women were financial, followed by health problems (**Table 40**). Social welfare is known as a crucial component of HIV/AIDS care. The Department of Health will improve access to health care for mothers and their infants first on a pilot basis before expanding the programme.

Table 40 Problems since delivery stated by HIV positive women

Problems since delivery	# (%) total =54
Health	13 (24%)
Accommodation	7 (13%)
Child care	5 (9%)
Financial	34 (63%)
Caring for partner/sick relative	7 (13%)
Relationship difficulties with husband/partner	4 (7%)
Relationship difficulties with family/family member	3 (6%)
Coping Have you found it difficult to cope following VCT? Have you ever thought about hurting yourself/killing yourself Have you ever tried to hurt yourself/kill your self	 44 (81.5%) 9 (17%) 1

Summary and conclusions Tool 11

54 HIV positive women were interviewed. The majority had had some information on PMTCT before attending ANC. 91% had learned about their HIV test result during this pregnancy. The majority of women (47/54, 87%) said that they had been given adequate information to make a decision about HIV testing and 52/54 (96%) had had adequate information to understand what their test results meant. Only 38/54 (70%) said that they had received sufficient information on health and social services available to them. Nearly all women (53/54 (98%)) felt that they had made the right decision to have an HIV test. 28/54 (52%) of women wanted to terminate their pregnancy after receiving the HIV test result but did not[9]. Only 1/36 (3%) of women would recommend HIV testing to partner. 2/54 had already recommended HIV testing to their partner. The Department of Health recommends partner notification. The counselling strategy to encourage HIV positive women should be revisited.

Knowledge about heterosexual HIV transmission was adequate but 24/54 (44%) did not know that condom use during sex could prevent HIV transmission. Most women did know that HIV can be transmitted through breastfeeding, but only 46/54 (85%) knew about HIV transmission during pregnancy and labour. Only 46/54 (85%) understood that there were medicines to prevent PMTCT of HIV. Only 13/54 (24%) understood that formula would prevent their baby to being HIV positive. Quality of counselling would need further improvement to make women fully understand prevention of HIV transmission through condom use and the interventions available to prevent mother to child transmission.

HIV infected women had experienced breaching confidentiality through family members and were concerned about being identified as having HIV because of taking ARV or formula feeding. Guidance on confidentiality would also include family members. Fear of breaching confidentiality because of formula feeding and taking ARVs could be tackled through improved counselling.

[9] Abortion/termination of pregnancy is considered illegal in Thailand

The most pressing problems were financial, followed by health problems. Social welfare is known as a crucial component of HIV/AIDS care. The Department of Health will improve access to health care for mothers and their infants first on a pilot basis before expanding the programme.

4.13 Comparison of interviews with *seropositive* and *seronegative* women

Demographic data

There were no significant differences in the educational level of women testing seropositive or seronegative. However, seropositive women had slightly lower incomes than seronegative and seropositive women were more likely to be single than seronegative (**Table 41**).

Table 41 Demographic information

Demographic information	HIV +ve # (%) total=54	HIV –ve # (%) total=75
Education		
Less than primary	4 (7%)	1 (1%)
Primary	33 (61%)	44 (59%)
Junior high	11 (20%)	15 (20%)
High school	1 (2%)	6 (8%)
Basic vocational	1 (2%)	3 (4%)
College or higher	2 (4%)	2 (3%)
None	2 (4%)	4 (5%)
Marital status		
Single	11 (18.5%)	0
Married	44 (81.5%)	75 (100%)
Total family income		
None	2 (4%)	0
< 2,500	23 (43%)	19 (25%)
2,500 – 4,999	19 (35%)	20 (27%)
5,000 – 9.999	7 (13%)	25 (33%)
10,000 – 14,999	2 (3.7%)	8 (11%)
> 15,000	0	3 (4%)

Source of information on PMTCT

More seropositive women had received information on PMTCT through health institutions (**Table 42**)

Table 42 Source of information on PMTCT

Source of information on PMTCT	HIV +ve # (%) total=54	HIV –ve # (%) total=75
Health centre	6 (11%)	13 (17%)
Community hospital	16 (30%)	14 (19%)
General hospital	7 (13%)	6 (8%)
Regional hospital	12 (22%)	7 (9%)
Volunteer	0	1 (1%)
Media	12 (22%)	27 (36%)
School/study site	0	7 (9%)

Knowledge about HIV and MTCT and PMTCT

There was no significant difference in knowledge about HIV between the seropositive and seronegative women (**Table 43**).

Table 43 HIV transmission knowledge

	HIV +ve total = 54			HIV –ve total = 75		
	Yes (%)	No (%)	D/K	Yes (%)	No (%)	D/K
HIV transmission HIV transmitted when M has sex with +ve F	100	0	0	99	0	1
HIV transmitted when F has sex with +ve M	98	0	2	100		
Condom use during sex with an +ve partner can prevent HIV transmission	48 (always) 7 (not perfect)	44	0	44 (always) 10 (not perfect)	45	0
MTCT F can infect their babies during pregnancy & labour	85	15	0	95	5	0
F can infect their babies through breastfeeding	96	4	0	92 1 (not always)	7	0
Are there medicines available to PMTCT?	89	4	8	44	36	20
Why are you offered an HIV test when you are pregnant? To find out my HIV status To receive medicines to prevent my baby being HIV +ve To receive formula to prevent my baby being be HIV +ve To discontinue pregnancy if I am HIV +ve I do no know	52 24 9 4 4			53 20 0 5 3		

Family planning following VCT

More HIV infected women had had tubal ligation than HIV negative women (**Table 44**)

Table 44 Family planning method used.

Family planning method used	HIV + ve # (%) (total 46)	HIV –ve # (%) (total 65)
Tubal ligation	22 (47.8)	19 (29%)
OCP	7 (15%)	16 (25%)
Injection	13 (28%)	22 (34%)
Norplant	2 (4%)	2 (3%)
IUD	0	1 (1.5%)
Condom*	2 (4%)	2 (3%)
Natural	0	3 (5%)

*condom as sole method of family planning.

Recommending HIV testing and disclosure of HIV test results

The majority of both seronegative and seropositive women thought that they had made the right decision to undergo HIV testing. The majority had already discussed HIV testing with their husbands/partners and 39% of seropositive and 56% of seronegative women's partners had already been tested (**Table 45**).

Table 45 HIV disclosure.

	HIV + ve # (%) (total 54)	**HIV –ve # (%) (total 75)**
Made right decision to have HIV test	53 (98%)	75 (100%)
Would recommend HIV testing to: • Pregnant friend/relative • Non-pregnant friend/relative • Husband/boyfriend	 45 (83%) 18 (33%) 1 (2%)	 70 (93%) 59 (79%) 15 (20%)
Have already recommend HIV testing to: • Husband/boyfriend • Friend • Family member	 25 (46%) 13 (24%) 8 (15%)	 41 (55%) 3 (4%) 10 (13%)
Have already discussed HIV testing with husband/boyfriend	37 (68.5%)	66 (88%)
Husband/boyfriend has already been tested	21 (39%)	42 (56%)

Conclusions and discussion

The evaluation gives an overall picture of the provisions of counselling services in the PMTCT programme from the provider perspective, the client perspective and the perspective of the policy maker at the central level.

The Thailand PMTCT programme in regions 3 and 6 has been fully operational since mid 1999. National Training Programme started PMTCT training for health care workers at all levels in early 1999. This training aimed to ensure the smooth integration of the PMTCT into the existing antenatal services. The importance and strengths of the programme was explained to all health workers and roles and responsibilities for the various components of the PMTCT programme were defined. The evaluation of the PMTCT programme in Region 3 and Region 6 took place during June to July 2000 approximately one year after full implementation of the PMTCT programme.

The evaluation consisted of analysis of data collected covering a 12-month period from 1.10.99 to 30 9.00 for the monthly record form and data an 8-month period from 1.10.99- 30.6.00 from interviews with health managers, providers and recipients and observation of counselling sessions. UNAIDS tools for monitoring and evaluating counselling services were adapted for use in the Thai PMTCT programme.

The tools developed for the PMTCT programme evaluation proved acceptable to both health care providers and clients. They were easy to administer and analyse.

29. Uptake of VCT and ZDV for PMTCT

During the first year of the programme antenatal attendance was high. In Region 3, 95% and in Region 6, 98% of women all giving birth had attended ANC. The proportion of women attending ANC and who had an HIV test was also very high. Data from the monthly record cards showed that in region 3, 99% and in region 6, 93% of *all* women who had ANC had had an HIV test.

For women who did receive HIV counselling and testing during their antenatal care and were identified as being HIV seropositive only 44% from region 3 and 54% from region 6 took the full course of ZDV for PMTCT (4 or more weeks ZDV) prior to delivery.

Increase ANC provision for HIV positive women

A disproportionately high number of seropositive women did not receive antenatal care (and thus did not receive HIV counselling and testing and interventions to PMTCT during the antenatal period) and presented in labour. In region 3, 206/1282 (16%) and in region 6, 27/520 (5.2%) of the seropositive pregnant women did not receive any antenatal care. This tendency for lower uptake of ANC care by HIV positive women was also seen in a study from a large Bangkok hospital, where15% of 303 HIV positive women who delivered had not received ANC. Women who had not received ANC were more likely to work or have partners who worked in construction or have a history of injection drug use [v]. Similarly in some parts of the US, 20% of HIV positive women give birth without having received ANC [vi].The Department of Health will consider developing strategies for improving identification of seropositive pregnant women and improving uptake of effective interventions to

PMTCT. Increasing antenatal coverage, particularly for women vulnerable from HIV infection is important as a greater proportion of seropositive pregnant do not receive antenatal care compared with uninfected women (p=<0.001 for both regions).

Identifying seropositive women during labour and delivery allows them to benefit from some ARV coverage for PMTCT. The rates of HIV testing during labour and delivery were different between regions (45.5% in region 6 and 80.9% in region 3). It should also be considered how to increase *ethical* uptake of HIV testing during labour.

It is also important to develop strategies for increasing the proportion of seropositive women who have not received any antenatal care and present in labour, who receive ZDV during labour. The possibility of providing Nevirapine administered as a single dose at onset of labour and a further single dose to the infant during the first 48 hours may be an option for women presenting for delivery without attending ANC, as this is more effective than single dose ZDV[vii].

30. Counsellors and counselling training

In this evaluation the majority of the counsellors interviewed felt comfortable with their counselling role, with less than 10% saying that they felt pressurised into doing counselling work. From other studies it has been shown that it is important for counsellors to have adequate training and ongoing training, support and supervision if they are to provide high quality counselling[viii]. Counsellors feel vulnerable and insecure if they have insufficient ongoing support[ix]. In regions 3 and 6 only 37/82 (45%) counsellors interviewed had received the full PMTCT training as recommended by DOH. Only 18/82 (22%) had had some ongoing training. Only 20/82 (24%) said that they had any technical support. Only 18/82 (22%) of counsellors said that they had a designated counselling supervisor to provide then with support in their counselling work. The lack of training, ongoing training, support as well as supervision of counsellors working for the PMTCT programme were most commonly noted problems with the PMTCT programme. This may have contributed to the low coverage of ZDV among HIV positive women. Other contributing factors may be the lack of a comprehensive communication strategy for HIV, ANC and PMTCT and the lack of awareness in the community about the PMTCT programme.

31. Confidentiality

One of the barriers to testing and fears described by women attending VCT is worries about confidentiality following testing[x,xi]. In regions 3 and 6 there were often inadequate systems in place to prevent breaching patient confidentiality unwittingly with OPD cards that have a visible sign to draw attention of HIV status and secure storage of notes and protected access to computerised HIV test results were not in place. HIV positive women were also concerned about ARV and formula feeding disclosing their status to the community.

32. The quality and content of counselling

Observations of both individual and group pre-test counselling sessions revealed that most counsellors provided relevant information on HIV testing, MTCT and PMTCT. The main area that was poorly covered was discussion of the benefits of partner testing. Observation of counselling skills revealed some areas that could be improved on and future counselling training could address these.

Observations of the content of post-test and ongoing counselling showed that most areas were covered appropriately. Partner involvement and partner testing were however often not covered adequately.

33. Views of pregnant women

180 women were interviewed following counselling session. 51 women were interviewed following pre-test counselling and 75 seronegative and 54 seropositive women were interviewed following post-test/ongoing counselling. There were no significant differences in the educational level of women testing seropositive or seronegative. However, seropositive women had slightly lower incomes than seronegative women did and seropositive women were more likely to be single than seronegative women.

Women attending ANC had some information before attending ANC, mostly through the media. The majority of women interviewed following pre-test and post-test counselling were satisfied with information, and their interaction with their counsellor

At post-test most women who tested seropositive (49/54 (91%)) had learned about their HIV test result during the current pregnancy. VCT is thus an essential component of most PMTCT interventions. Although the decision to test should always be informed and entirely voluntary in some PMTCT projects women have said that they felt compelled to be tested as part of a PMTCT study[xii]. However in this operational setting the majority of women (47/54, 87%) said that they had been given adequate information to make a decision about HIV testing and 52/54 (96%) had had adequate information to understand what their test results meant. Nearly all women (53/54 (98%)) felt that they had made the right decision to have an HIV test. 28/54 (52%) of women, however, said that they had wanted to terminate their pregnancy after receiving the HIV test result but did not[10]. The only major criticism was the lack of information about care following VCT. Only 38/54 (70%) of seropositive women said that they had received sufficient information on health and social services available to them

Following pre and post-test counselling sessions it would be hoped that seropositive pregnant women would be well informed about HIV and PMTCT. Although knowledge about heterosexual HIV transmission was adequate and most women knew that HIV could be transmitted through breastfeeding, only 85% knew about HIV transmission during pregnancy and labour. 85% understood that there were medicines to prevent PMTCT. Only 24% of women knew that using infant formula instead of breastfeeding could prevent HIV transmission to their infant. This highlights the need for clarifying information and checking for understanding during counselling.

Many of the seropositive women said that they had experienced breaches in confidentiality by family members and were concerned about being identified as having HIV because of taking ARV or formula feeding. Guidance on maintaining confidentiality could also include involvement of family members in counselling sessions. Fear of breaching confidentiality because of formula feeding and taking ARVs could also be tackled through counselling together with husbands/partners and/or family members.

34. Disclosure to partner and partner testing

There are many advantages for women to share their HIV status following VCT, particularly with their husbands/partners. However there are many barriers to discussing HIV test results with partner/s[xiii]. Information from other PMTCT sites has shown very low levels of disclosure to sexual partners and low numbers of men agreeing to HIV testing in most settings[xiv].

[10] Abortion is considered illegal in Thailand.

The Department of Health in Thailand recommends partner notification. In regions 3 and 6 disclosure to husbands/partners was much higher than has been reported elsewhere. 68% of seropositive and 88% of seronegative women had already discussed HIV testing with their partners. HIV testing of partners was also relatively high compared with other settings. 39% of seropositive and 42% of seronegative women's partners had already had an HIV test (n/s). Ideally all women should be able to share their HIV test with their partners and he should also undergo testing, preferably together with his wife/partner. However, in some countries women are unable to disclose their HIV status to their sexual partners because of fear of being blamed, abandoned or abused for their HIV infection[xv]. It is therefore understandable that some women may not be able to share their HIV status with their partners. In this evaluation it is disclosure was high but not universal, possibly reflecting that women were able to make decisions whether or not to disclose and did not feel pressurised into disclosing.

Problems for seropositive women

In this study the most commonly stated problem for seropositive women was financial difficulties (63% of women), followed by health problems (24% of women). Other worries included accommodation worries (13%), caring for sick partner/relative (13%) and relationship difficulties (7%) and family difficulties (6%). However, referrals to HIV/AIDS care and social support services were not made in the majority of sites. This may reflect a lack of real or perceived need for referrals by health care staff as well as a lack of services for HIV asymptomatic and HIV symptomatic adults and children. The Department of Health aims to improve access to health care for mothers and their infants following VCT/PMTCT interventions, initially on a pilot basis before expanding the programme.

High levels of domestic violence have been reported in some PMTCT projects where women have disclosed their HIV status to their husbands/partners[9]. In this study although 15% of seropositive women said that they had experienced at least one episode of domestic violence in the preceding 5 years only one woman said this was related to her HIV positive status. Violence against women, perpetrated by husbands/partners is common in most societies. In other studies higher levels of domestic violence has also been reported by seropositive than seronegative women, but as in this study it may not be as a consequence of a positive HIV status but due to other underlying social factors.[xvi]

Coping following VCT

82% of seropositive women said that they had found it difficult to cope following VCT. 17% of seropositive women said that they had actually contemplated harming themselves or committing suicide. One woman reported that she had actually tried to harm herself. Emotional distress on learning that one has a seropositive HIV result is a rational response. However the aim of counselling is to help the person understand, accept and cope with the diagnosis and prevent serious reactions such as suicide or long term intractable depression. In other VCT services adverse long-term emotional problems have been reported as being low with high quality post-test and ongoing counselling[xvii]. Improving counselling and support services for seropositive pregnant women could be important in helping pregnant women in Thailand cope better following VCT and minimising long-term distress.

Infant feeding

The use of breast milk substitutes has been shown to reduce infant infections by 44%[xviii]. Replacement feeding with infant formula is recommended for seropositive

women in Thailand. In many PMTCT projects uptake of replacement feeding by seropositive women has been low[xix]. However, in Thailand replacement feeding is acceptable and women are not stigmatised if they do not breastfeed. 96% of seropositive women in this study said that they were using infant formula. There is concern that seronegative women will also use replacement feeding if this is promoted for seropositive women (the 'spillover effect'). However in Thailand only 13% of HIV negative women said that they were formula feeding, the majority of women were breastfeeding or mixed feeding.

Family planning and HIV prevention

In this study tubal ligation was the preferred method of family planning for seropositive woman.

3/42 counsellors recommended IUDs as a method for family planning to HIV positive women. However, the DOH does not recommend IUDs as a method of FP for HIV positive women, and this should be addressed in future PMTCT/FP training.

9% of seropositive and 32% of seronegative women said that they were planning to have another baby.

Seropositive women were recommended to use condoms in addition to other methods of family planning by 41/48 (85%) of counsellors. However, the understanding by both seropositive and seronegative mothers that condom use could prevent HIV transmission when having sex with a seropositive partner was poor. Some of the women interviewed post delivery may have attended ANC before the initiation or at the very beginning of the PMTCT programme and may not have benefited from adequate HIV prevention counselling. Awareness to use condoms in marriage and relationships other than commercial sex is low and this area should receive greater emphasis in all counselling sessions.

35. Quality control of HIV testing

Only 11/19 (58%) of hospitals participate in and external quality control system for HIV testing. It has been noted form other HIV testing services that without adequate quality control systems there is a potential for clerical and errors and false positive test results, the latter being particularly important in lower prevalence settings.

Recommendations

- **Expansion of the VCT/PMTCT counselling training programme**. The Department of Health is encouraging the Regional Health Promotion Centers to increase the training to include all nurse/counsellors in ANC/MCH services for the next phase of the implementation in order to improve the coverage and quality of the programme. Training of counsellors to provide better support for women who test seropositive should be provided. Fear of breaching confidentiality because of formula feeding and taking ARVs could be addressed through improved counselling and counselling involving husbands/partners or trusted family members.

- **Strengthen ongoing counselling, support and referral for seropositive women**. For the maximum impact of PMTCT, ongoing counselling (particularly about infant feeding issues, infant testing, disclosure to partner and partner testing, access to care and support and HIV prevention) should also be available in the post-natal period. It may be appropriate to have more counsellors/nurses trained who work on the post-partum ward/clinic to ensure that follow-up/supportive counselling and referral to care and support services is not overlooked. Improved educational material about PMTCT for pregnant women their partners and families should be developed.

- **Provide enhanced counsellor support, follow-up training and supervision**. Ongoing counselling support for counsellors is overlooked in many VCT services. To prevent burnout and to ensure or maintain quality of counselling it is recommended that counsellors are provided with both, technical and emotional support. Informal arrangement or a reliance on family and friends is often inadequate and it is suggested that regular support and supervision be built in to counselling programmes.

- **Counselling and care for women who present in labour**. It is recommended that the DOH will develop a strategy for women presenting in labour without an HIV test result and who wish to be tested and benefit from PMTCT interventions.

- **Reaching women who are vulnerable to HIV infection**. It is noted that seropositive women are more likely to present in labour without having attended antenatal care than seronegative women are. This means that some women, who could most benefit from PMTCT interventions, only receive intra-partum and/or post-partum care. Increasing access to ANC for vulnerable women and ways of making information about the benefits of VCT and PMTCT more widely known should be sought.

- **Ongoing medical care for seropositive mothers and infants**. Access to HIV/AIDS care and support for seropositive mothers and their children after delivery could be improved. It is planned that a pilot project to study the operational and logistic factors for this intervention to be conducted in one region.

- **Strengthen confidentiality**. Guidance on confidentiality in MCH services needs strengthening not only for health care workers, but also for family members and the community. The DOH recommends hospitals to remove visible signs on OPD cards, and ensure secure storage of notes and HIV test results as well as secure access to computerised data. The Department of health recommends that the

HIV test result should not be disclose to anyone other than the HIV tested woman. Joint counselling sessions with husbands and/or trusted family members should be encouraged so that seropositive women can be supported following VCT. This 'shared confidentiality' can also help in adherence and uptake of PMTCT interventions.

- **Improved HIV prevention education.** The Department of Health recommends increasing public awareness about condom use and sexual behaviour change especially among the reproductive age group. The DOH will emphasise that condoms can be used as a means of family planning *and* prevention of sexually transmitted infections including HIV (Dual protection.) Dual protection has not been adequately promoted in Thailand. There has been a very comprehensive programme for increasing access to condoms and promoting condom use for sex workers and their clients resulting in a significant increase in condom use for these groups[xx]. However, many women do not consider condom use with their regular sexual partners. Furthermore, family planning practitioners do not recommend condoms for family planning, preferring to recommend methods such as hormonal contraceptives or IDUs.

- **External quality control of HIV testing.** The DOH recommends all hospitals to participate in the external quality control system for HIV testing and ensure availability of HIV test kits.

ANNEX

Tool 1 Monthly report form

Data will be collected from DOH from all hospitals Region 3 and Region 6 at provincial and regional level

District:_____ Month of Report _____

Province: _____ Year of Report _____

FROM ANC CLINICS

1 Number of women starting ANC ..... __ __ __women
- 1.1 Number of women who did not have HIV test ..... __ __ __women
- 1.2 Number of women who had HIV test ..... __ __ __women
  - 1.2.1 Number of women with HIV+ test..... __ __ __women
  - 1.2.2 Number of women with HIV- test ..... __ __ __women

FROM DELIVERY ROOMS

2 Number of women giving birth..... __ __ __women
- 2.1 Number with ANC ..... __ __ __women
  - 2.1.1 Number with positive HIV test..... __ __ __women
    - 2.1.1.1 Number who took only ZDV at least 4 weeks before delivery ..... __ __ __women
      - 2.1.1.1.1 Number with good compliance[1]..... __ __ __women
      - 2.1.1.1.2 Number with fair compliance[2]..... __ __ __women
      - 2.1.1.1.3 Number with poor compliance[3]..... __ __ __women
    - 2.1.1.2 Number who took only ZDV less than 4 weeks before delivery..... __ __ __women
    - 2.1.1.3 Number who took other antiretroviral with ZDV..... __ __ __women
    - 2.1.1.4 Number who took only other antiretroviral, not ZDV..... __ __ __women
    - 2.1.1.5 Number who did not take any antiretrovirals during pregnancy ..... __ __ __women
  - 2.1.2 Number with negative HIV test..... __ __ __women
  - 2.1.3 Number not tested for HIV..... __ __ __women
- 2.2 Number without ANC ..... __ __ __women
  - 2.2.1 Number with positive HIV test..... __ __ __women
    - 2.2.1.1 Number who took only ZDV during labor ..... __ __ __women
    - 2.2.1.2 Number who took other antiretrovirals with ZDV during labor..... __ __ __women
    - 2.2.1.2 Number who took only other antiretrovirals during labor, not ZDV..... __ __ __women
    - 2.2.1.3 Number who did not take antiretrovirals during labor..... __ __ __women
  - 2.2.2 Number with negative HIV test..... __ __ __women
  - 2.2.3 Number not tested for HIV..... __ __ __women

3 Number of live births born to women with positive HIV test ..... __ __ __children
- 3.1 Number of children who received only ZDV at birth..... __ __ __children
  - 3.1.1 Number of children intending to get ZDV for 1 week..... __ __ __children
  - 3.1.2 Number of children intending to get ZDV for 6 weeks..... __ __ __children
- 3.2 Number of children who received other antiretroviral with ZDV at birth..... __ __ __children
- 3.3 Number of children who received only other antiretroviral at birth..... __ __ __children
- 3.4 Number of children who did not start antiretroviral at birth..... __ __ __children

4. Report on formula supply
- 4.1 Number of children who received formula before discharge .....__ __ __children
- 4.2 Amount of formula given to children in 4.1 before discharge..... __ __ __.__Kg

---

[1] Not having missed more than 2 doses ZDV

[2] Forgot to take 3-5 doses not continuously or forgot to take ZDV in more than 48 hours between 2 doses

[3] Forgot to take > 5 doses ZDV in more than 48 hours

FROM PEDIATRIC CLINICS

5. Number of children born to HIV positive mothers who received formula this month as out patient.....__ __ __children

5.1 Number of children born to HIV positive mothers <1 year old who received formula this month.....__ __ __children

5.1.1 Amount of formula used by children in 5.1 .....__ __ __.__kg

5.2 Number of children born to HIV positive mothers 1-2 years who received formula this month .....__ __ __children

5.2.1 Amount of formula used by children in 5.2 __ __ __.__kg

Tool 2
for Evaluating the Logistics of VCT in ANC/ Labor Room/ Post Partum Ward and Well Baby Clinic

Respondent =
Chief of OB/GY (Regional Hospital, Provincial Hospital, District Hospital > 30 beds) or hospital director (District Hospital < 30 beds) and
Head nurse of MCH services

Please fill in these questionnaires with the help of your colleagues. We will come to collect the questionnaires on …….. At that time you may ask for clarification and discuss the answers.
Learning about your experiences is very important. It will help the Ministry of Public Health to improve the programme. We will share the results of this evaluation with you after the data are analyzed .

Name of hospital	Date
Name of respondent	Position
Regional hospital Provincial hospital District hospital	Region Province District

Self administered questionnaire

1. Which services do you offer for pregnant women
   pre-test counselling
   group how many session per week (average) ____
   individual how many session per week (average) ____

   post-test counselling HIV negative women
   group how many session per week (average) ____
   individual how many session per week (average) ____

   post-test counselling HIV positive women
   group how many session per week (average) ____
   individual how many session per week (average) ____

2. If pre-and post test counselling are undertaken, does the hospital follow the National Policy Guidelines on HIV pre- and post test counselling ?
   Yes No

3. How many counsellors currently work in

General HIV counselling	__ __
MCH services (total #)	__ __
ANC/Well Baby Clinic	__ __
Labour room/post partum ward	__ __
Other _ _ ,please explain_____	

4. How many counsellors have received **training for basic HIV counselling** in the hospital?

MCH services (total #)	__ __
ANC/Well Baby Clinic	__ __
Labour room/post partum Ward	__ __
Other _ _ ,please explain_____	

5. How many counsellors have received **training for PMTCT counselling** in the hospital?

MCH services (total #)	__ __
ANC/Well Baby Clinic	__ __
Labour room/post partum Ward	__ __
Other _ _ ,please explain_____	

6. How many counsellors have received **training for basic HIV counselling *and* PMTCT counselling** in the hospital?

MCH services (total #)	__ __
ANC/Well Baby Clinic	__ __
Labour room/post partum Ward	__ __

7. What were the selection criteria for assigning staff to attend the PMTCT counselling training?

   Please describe_____
   _____

8. When counsellors have **technical problems**[11] who provides technical support?
   - supervisor
   - colleague/team
   - no formal line of support
   - counselling network, meeting __ times per month
   - other, please describe_____

9. When counsellors need **emotional support**[12] who provides emotional support?
   - supervisor
   - colleague/team
   - counselling network, meeting __ times per month
   - no formal line of support
   - other, please describe_____

[11] Technical support includes help with difficult counselling cases, information about recent advances in MTCT

[12] Emotional support means support for yourself when you have emotionally draining counselling cases

Level of services provision and utilization
during 1.10.99- 30.6.00

From ANC clinic

10. Number of women starting ANC..... __ __ __women
    10.1. Number of women receiving pre-test counselling
    10.2.Number of women who did not have HIV test..... __ __ __women
    10.3.Number of women who had HIV test..... __ __ __women
        10.3.1 Number of women who returned for post-test counselling..... __ __ __women
        10.3.2 Number of women with HIV- test..... __ __ __women
        10.3.3 Number of women with HIV+ test..... __ __ __women
            10.3.3.1 Number of women who received ZDV __ __ __women
            10.3.3.2 Number of women who wanted to discontinue pregnancy with known positive HIV status women __ __ __women

Labour

11. What happens if a woman comes during early labour without having had a previous HIV test?
    Do you offer pre-test counselling Yes No
    Do you offer HIV testing Yes No

12. If you offer HIV testing during labour, when is the blood drawn?
    With pre-test counselling Yes No
    Without pre-test counselling, but pre-test counselling offered post-partum Yes No
    Without knowledge of the woman Yes No
    Not at all before delivery, but post partum Yes No
    No common strategy Yes No

13. When the HIV test result from labour is positive, what do you offer the woman
    ZDV during labour to pregnant women
    ZDV for the baby
    Infant formula for the baby

Privacy

14. Do you have adequate space to ensure post-test counselling sessions can be private?
    Yes, there is adequate space
    There is some private space, but not enough
    No

Confidentiality

15. Does the hospital have a written policy on confidentiality? Yes No
    If yes, please tick any of the following the steps taken (may be more than 1)
    Test result disclosed only to person tested Yes No
    Test result disclosed to husband without obtaining consent of tested woman Yes No
    Test result disclosed to other family members without obtaining consent of woman tested Yes No
    OPD cards of HIV positive women wearing a visible sign to draw attention of HIV status? Yes No
    OPD cards kept in a locked filing cabinet or room Yes No

System to protect confidential computerized information

Yes No No computer

16. Have any of the following staff received specific guidance about confidentiality?

Counsellors	Yes	No
Nurses in ANC/MCH services	Yes	No
Midwives	Yes	No
Laboratory staff	Yes	No
Non-counselling medical staff	Yes	No
Ward attendants	Yes	No
Ancillary staff (e.g. cleaners)	Yes	No

Others (specify)_____

Linkages

17. Did you refer HIV positive pregnant women to any of the following services inside the hospital or outside the hospital during 1.10.99- 30.6.00?

Medicine section	Often	Sometimes	Never
Social services	Often	Sometimes	Never
Other counselling services	Often	Sometimes	Never
NGOs	Often	Sometimes	Never
Family planning services	Often	Sometimes	Never
TB/chest clinic	Often	Sometimes	Never
STI services	Often	Sometimes	Never
Traditional healers	Often	Sometimes	Never
Spiritual/religious groups	Often	Sometimes	Never

Others (specify))_____

18. Do you feel there are adequate referral services within the hospital available, particularly for the needs of people who test positive?

Yes No

If not, please describe_____

19. Do you feel there are adequate referral services outside the hospital available, particularly for the needs of people who test positive?

Yes No

If not, please describe_____

_____

HIV testing methods

20. Where do you carry out HIV tests for pregnant women?

All testing done on site	Yes	No
Preliminary tests done on site, confirmations sent to other site	Yes	No
All testing carried out in other site	Yes	No

21. What HIV tests are used for testing pregnant women?

Rapid Test	Yes	No
ELISA	Yes	No
GPA	Yes	No
Others	Yes	No

Please, specify _____

Which of the above is most commonly used test type?_____

22. What is the time interval between taking blood and first results being available to the women?
    Same day 1- 7 days 1-2 weeks > 2 weeks

23. What is the time interval between taking blood and post-test counselling for the definitive (second/confirmatory) test results being available to HIV positive women?
    Same day 1- 7 days 1-2 weeks > 2 weeks

24. Describe HIV testing schedule employed[13]
    _____
    _____

25. Are you participating in any external quality control system for HIV testing?
    No …Yes If yes, please describe the procedure_____
    _____
    _____

26. Did you ever have shortage of HIV tests?
    Yes No No testing done at this site

    If yes, how many months / year
    Please expand why _____

Opening hours per day/ per week

27. How many days per week does the hospital offer pre-test counselling in ANC/MCH services?_____

28. How many days per week do counsellors provide post-test counselling in ANC/MCH services?_____

29. How many days per week does the hospital provide ZDV counselling in ANC/MCH services?_____

Cost and sustainability

30. Do you charge for HIV testing? No Yes
    If yes, Cost/ 1st test amount _____
    Cost/ 2nd test amount _____

31. Are there any pregnant women who do not pay? No Yes
    If yes what is the proportion of women who do not pay[14] _____
    How is the service funded?_____

Drug Supply

32. Number of days with shortage of or expired ZDV capsules for ANC during I.10.99-30.6.00 [15]? __ __

[13] for example, schedule for confirmation of test results, policy about testing in the window period
[14] If you do not have the number, please estimate approximate %
[15] If you do not have the number, please estimate

33. Number of days with shortage of or expired ZDV syrup for ANC during I.10.99-30.6.00 [16] ? __ __

[16] If you do not have the number, please estimate

Service delivery

34. Have you done anything to facilitate the implementation of MTCT services within your hospital ?

For example:

Appointed someone to be in charge of the MTCT programme Yes No

Ensured that there is always someone trained in PMTCT available during clinic times Yes No

Sensitised other hospital personnel in MTCT Yes No

Other please describe _____

Problems

35. Were there any problems occurring in the hospital during introduction and provision of VCT and ZDV counselling? (may be more than 1)

Work load	Yes	No
Lack of training	Yes	No
Lack of ongoing training	Yes	No
Lack of emotional support	Yes	No
Lack of technical support	Yes	No
Lack of administrative support	Yes	No
Lack of supervision	Yes	No
Staff moved to other posts within the hospital	Yes	No
Staff left the hospital to work somewhere else	Yes	No
Completing log book	Yes	No
Completing the monthly report form	Yes	No
Other,	Yes	No

Please explain_____
_____

36. Is there a need to improve VCT/ZDV counselling in ANC/MCH services? (may be more than 1)

Counsellor training	Yes	No
On going training for counsellors	Yes	No
Counsellor support group	Yes	No
Counsellor supervision	Yes	No
Patient education material	Yes	No
Other	Yes	No

Please explain_____
_____

37. What do you think is the main benefit of the implementation of the PMTCT programme?
Please explain_____
_____

38. What do you think is the main problem with the implementation of the PMTCT programme ?
Please explain_____
_____

Tool 3 for Evaluation of Reproductive Issues

Respondent = all counsellors

Please fill in these questionnaires with the help of your colleagues. We will come to collect the questionnaires on …….. At that time you may ask for clarification and discuss the answers.
Learning about your experiences is very important. It will help the Ministry of Public Health to improve the programme. We will share the results of this evaluation with you after the data are analyzed .

Name of hospital	Date
Code	
Regional hospital Provincial hospital District hospital	Region _____ Province _____ District _____

Self administered questionnaire

1. How many women attended ANC during 1.10.99- 30.6.00? _____

2. How many women tested HIV positive in ANC during 1.10.99- 30.6.00? _____

3. Is **tubal ligation** for family planning for HIV positive women recommended?
   To all women To most women To some women To no women

   How many women choose tubal ligation during 1.10.99- 30.6.00? _____

4. Are **condoms** recommended for family planning for HIV positive women?
   To all women To most women To some women To no women

   How many HIV positive women choose condoms for family planning during 1.10.99- 30.6.00? _____

5. Are **hormonal contraceptives** recommended for HIV positive women?
   To all women To most women To some women To no women

   How many HIV positive women decided to use hormonal contraceptives for family planning during 1.10.99- 30.6.00?
   Pill ____
   Depot Provera ____
   Norplant ____
   Other ____

6. Are **IUDs** recommended for HIV positive women?
   To all women To most women To some women To no women
   How many HIV positive women decided to use IUD for family planning during 1.10.99- 30.6.00? ____

7. Do you recommend HIV positive women to use **condoms for HIV prevention *in addition*** to other family planning methods other than a condoms?

   To all women To most women To some women To no women

Tool 4
for Counsellor Evaluation

Respondents = all counsellors

Please fill in these questionnaires with the help of your colleagues. We will come to collect the questionnaires on …….. At that time you may ask for clarification and discuss the answers.
Learning about your experiences is very important. It will help the Ministry of Public Health to improve the programme. We will share the results of this evaluation with you after the data are analyzed .

Name of hospital	Date
Position of respondent	Code
Regional hospital Provincial hospital District hospital	Region _____ Province _____ District _____

Self administered questionnaire
36. Background

1. What is your current job?
   Professional nurse — Technical nurse
   Midwife — Psychologist
   Technical officer — Physician
   Other (please, specify) _____

2. Where do you currently work?
   ANC / Well baby clinic
   Labor room
   Post partum ward
   Other (please specify) _____

Selection

3. Do you feel that you have been pressurised into doing counselling?
   Yes No

Training

4. Have you ever been trained in **basic HIV Counselling** No Yes
   If yes, how many days?_____ Year of training_____
   If yes, How would you rate your counselling training?
   Very good □ Good □ Not so good □ Inadequate □

5. Have you ever been trained in **HIV & MCH counselling** No Yes
If yes, how many days? _____ Year of training_____
If yes, How would you rate your counselling training?
Very good Good Not so good Inadequate

6. Have you ever been trained in **HIV & MCH/ZDV counselling**
No Yes

If yes, how many days? _____ Year of training_____

If yes, How would you rate your counselling training?
Very good Good Not so good Inadequate

7. Have you had any **other training related to HIV counselling**
No Yes
If yes, please describe type of training
_____

Ongoing Training

4. Are there any areas in which you feel you need *more* training?
_____

5. Have you had any ongoing training? Yes No

6. Do you think ongoing training would be a good idea? No Yes
If yes, describe how it might, or might not, help?
_____

Support

7. Where do you get help if you need **technical**[17] support?
Please explain,
_____

8. Where do you get help if you need **emotional**[18] support?
Please explain,
_____

Supervision

[17] Technical support includes help with difficult counselling cases, information about recent advances in MTCT
[18] Emotional support means support for yourself when you have emotionally draining counselling cases

9. Do you have access to a designated counselling supervisor to provide you with support and supervises your work?

No Yes

If yes, who _____

Satisfaction & "Burnout"

10. In your counselling duties, do you feel valued by:

Clients Yes always Yes sometimes Never

The hospital director/chief of section

Yes, always Yes, sometimes Never

Colleagues Yes, always Yes, sometimes Never

11. Do you feel that you receive support from the **hospital administration**?

Yes, always Yes, sometimes Never

12. Are you given **adequate time** in your job to carry out your counselling duties?

Yes, always Yes, sometimes Never

13. Please indicate how you feel about the following statements:

"I feel emotionally drained by my work as a counsellor in ANC/MCH services"

always often occasionally never

"My work is very stressful"

always often occasionally never

"My work is very rewarding"

always often occasionally never

"My work environment is very stressful"

always often occasionally never

"I learn something new in my work every day"

always often occasionally never

"I feel isolated in my work"

always often occasionally never

"I have problems communicating with my colleagues"

always often occasionally never

"I can help my clients"

always often occasionally never

"I have no confidence in my clinical skills"

always often occasionally never

14. How long have you been doing MTCT/HIV counselling? ____

15. How many **hours per day** do you do MTCT/HIV counselling? ____

16. How many **days per week** do you do counselling? ____

17. How many clients do you see per day? (average) ____

18. How do you see your future in counselling?

I will go on with my counselling job for the foreseeable future

I find counselling to stressful/difficult and want to find a new job

I want to move to another hospital/job

Other (explain) _____

Tool 5
for evaluation of PRE TEST COUNSELLING contents

Respondents = observers of counselling sessions

Name of hospital	Date	Time start
Name of observer	Time stop	
Regional hospital Provincial hospital District hospital	Region _____ Province _____ District _____	

1. Pre-test counselling during pregnancy
   Individual counselling Group counselling
   How long is the session?_____

2. Educational material used
   Video Leaflets Flipchart/poster others

During the session have the following occurred?

- Information on of HIV transmission and risk behaviours Yes No
- Information on safer sex practices Yes No
- Misconceptions corrected[19] Yes No
- Information concerning the HIV test given[20] Yes No
- Full information about HIV in pregnancy and the risk of MTCT Yes No
- Possible benefits of knowing her status and interventions available if the result is positive[21] Yes No
- Implications of a +ve result for her baby Yes No
- Implications of a +ve result for future children Yes No
- Implications of a +ve result for decisions about infant feeding Yes No
- Implications of a +ve result for her relationship with baby's father Yes No
- Discussions around the benefits of testing together baby's father Yes No
- Implications and benefits of sharing a +ve result with baby's father Yes No
- Explaining that testing is not mandatory and that she will not be denied access to antenatal care or other services if she chooses not to be tested Yes No
- Understanding checked for Yes No
- Adequate time for questions and clarifications Yes No

[19] e.g. sharing toilet, bathroom, dishes, etc does not transmit HIV
[20] e.g. process of testing, meaning of possible test results, window period
[21] including making it clear that ARV therapy for PMTCT cannot be given to women whose status is not known

Counselling skills

Function	Skills		Comments
Interpersonal relationship	• Greets clients • Engages client/group in conversation	Yes No Yes No	
Group counselling	• Gives information in clear and simple terms • Responds to patients questions • Has up-to-date knowledge about HIV • Repeats and reinforces important information • Allows all members to participate • Seeks clarification about information given/discussed • Directs discussion appropriately • Checks for understanding/ misunderstanding • Summarizes main issues discussed	Yes No Yes No Yes No Yes No Yes No Yes No Yes No Yes No	
Individual counselling	• Uses appropriate balance of open and closed questions • Uses silence well to allow for self-expression (does not interrupt client • Avoids premature conclusions • Gives client time to absorb information and to respond • Summarizes main issues discussed	Yes No Yes No Yes No Yes No Yes No	

Tool 6
for evaluation of POST TEST COUNSELLING contents for HIV POSITIVE pregnant women

Respondents = observers of counselling sessions

Name of hospital	Date	Time start
Name of observer	Time stop	
Regional hospital Provincial hospital District hospital	Region _____ Province _____ District _____	

1. Individual counselling Group counselling
   How long is the session?_____

2. Educational material used
   Video Leaflets Flipchart/poster others

3. Number of visit _____

4. Month of gestation _____

During the session have the following occurred?

- Results given simply and clearly Yes No
- Time allowed for the result to sink in Yes No
- Checking for understanding Yes No
- Discussion of the meaning of the result for the client Yes No
- Discussion of benefits and risks of sharing information about HIV status with partner, family, etc. Yes No
- Dealing with immediate emotional reactions Yes No
- Checking adequate immediate support available Yes No
- Discussion of follow-up care and support Yes No
- Discussion about ARVs for PMTC Yes No
- Discussion about infant feeding options Yes No
- Discussion about safer sex Yes No
- Options and resources identified Yes No
- Immediate plans, intentions and actions reviewed Yes No
- Follow-up visits for ARV and infant feeding options arranged Yes No

Counselling skills

Function	Skills		Comments
Interpersonal relationship	• Greets clients • Engages client/group in conversation	Yes No Yes No	
Group counselling	• Gives information in clear and simple terms • Responds to patients questions • Has up-to-date knowledge about HIV • Repeats and reinforces important information • Allows all members to participate • Seeks clarification about information given/discussed • Directs discussion appropriately • Checks for understanding/ misunderstanding • Summarizes main issues discussed	Yes No Yes No Yes No Yes No Yes No Yes No Yes No Yes No	
Individual counselling	• Uses appropriate balance of open and closed questions • Uses silence well to allow for self-expression (does not interrupt client • Avoids premature conclusions • Gives client time to absorb information and to respond • Summarizes main issues discussed	Yes No Yes No Yes No Yes No Yes No	

Tool 7
for evaluation of ARV counselling content for HIV POSITIVE pregnant women for MTCT programme attending AFTER 32 WEEKS

Respondents = observers of counselling sessions

Name of hospital	Date	Time start
Name of observer	Time stop	
Regional hospital Provincial hospital District hospital	Region _____ Province _____ District _____	

1. Individual counselling Group counselling
   How long is the session?_____

2. Educational material used
   Video Leaflets Flipchart/poster others

3. Number of visit _____

4. Month of gestation _____

37. Have specific questions about prevention of HIV transmission been covered?

- Information about safer sex and prevention of HIV and STIs Yes No
- Discussion of a personal risk reduction plan Yes No
- Discussion about discordancy Yes No
- Discussion about disclosure of status to partner Yes No
- Discussion of partner being offered HIV testing Yes No

Have specific questions about planning for the future been covered?

- Information about care of the child [22] Yes No
- Follow-up plans made and referrals where necessary Yes No

Have specific questions about MTCT and ARV treatment been covered?

- Previous ARV use Yes No
- Not a cure Yes No
- Need to attend maternity services Yes No
- Decision to take ZDV in voluntary Yes No
- Need to take ZDV as prescribed Yes No
- The regimen explained Yes No
- ANC dose and labour dose Yes No
- What to do if the woman forgets to take ZDV Yes No
- The need to take medicines continually according to the regime and the dangers of taking ZDV erratically Yes No
- The possible side effects and when to seek medical help Yes No
- Other medicines being taken Yes No
- Understanding checked for Yes No

[22] including nutritional advice and seeking early treatment for illnesses

Counselling skills

Function	Skills		Comments
Interpersonal relationship	• Greets clients • Engages client/group in conversation	Yes No Yes No	
Group counselling	• Gives information in clear and simple terms • Responds to patients questions • Has up-to-date knowledge about HIV • Repeats and reinforces important information • Allows all members to participate • Seeks clarification about information given/discussed • Directs discussion appropriately • Checks for understanding/ misunderstanding • Summarizes main issues discussed	Yes No Yes No Yes No Yes No Yes No Yes No Yes No Yes No	
Individual counselling	• Uses appropriate balance of open and closed questions • Uses silence well to allow for self-expression (does not interrupt client • Avoids premature conclusions • Gives client time to absorb information and to respond • Summarizes main issues discussed	Yes No Yes No Yes No Yes No Yes No	

Tool 8
for evaluation of post test counselling content for HIV NEGATIVE pregnant women in MTCT programme

Respondents = observers of counselling sessions

Name of hospital	Date	Time start
Name of observer	Time stop	
Regional hospital Provincial hospital District hospital	Region _____ Province _____ District _____	

1. Individual counselling Group counselling
   How long is the session? _____

2. Month of gestation _____

3. Educational material used
   Video Leaflets Flipchart/poster others

Post-test counselling for -ve women attending maternity services

- Information about safer sex and using condoms to prevent infection (especially during pregnancy and breastfeeding) Yes No
- Explain about discordancy Yes No
- Discuss benefits of partner testing Yes No
- Explain about window period in high risk group Yes No
- Offered second test immediately prior to delivery Yes No

Counselling skills

Function	Skills		Comments
Interpersonal relationship	• Greets clients • Engages client/group in conversation	Yes No Yes No	
Group counselling	• Gives information in clear and simple terms • Responds to patients questions • Has up-to-date knowledge about HIV • Repeats and reinforces important information • Allows all members to participate • Seeks clarification about information given/discussed • Directs discussion appropriately • Checks for understanding/ misunderstanding • Summarizes main issues discussed	Yes No Yes No Yes No Yes No Yes No Yes No Yes No Yes No	
Individual counselling	• Uses appropriate balance of open and closed questions • Uses silence well to allow for self-expression (does not interrupt client • Avoids premature conclusions • Gives client time to absorb information and to respond • Summarizes main issues discussed	Yes No Yes No Yes No Yes No Yes No	

Tool 9
for evaluation of CLIENT SATISFACTION AND UNDERSTANDING following pre-test counselling

Respondents = exit interviews with pregnant women following pre-test counselling

Interviewer	Date

Code No. _____
Name of Hospital_____
_____Province_____
_____

Regional hospital Provincial hospital District hospital	Region _____ Province _____ District _____

Introduction
Good morning! My name is _____. I am from the Ministry of Public Health. We are working within Programme for the Prevention of HIV Transmission from Mother to Child. We would like you to answer some questions. Learning about your experiences is very important. It will help the Ministry of Public Health to improve the programme.
You do not have to answer any question if you do not want to and you can stop the interview at any time.
The information you give is confidential. The nurses, doctors and other people will not be told what you said.

Please indicate
Group counselling Individual counselling

Duration of session approximately……. minutes

Demographic information

1. Age ____

2. What is the highest educational level you completed?
   Less than primary
   Primary
   Junior high
   High school
   Basic vocational
   Advanced vocational
   College or higher

3. Would you say you are currently
   Single
   Together with your husband/partner

If single, is this because you are
   Separated
   Widowed
   Never married
   Other, please describe_____

4. What is your total family income (approximately)?

1)None	4) 5,000 – 9.999	7) Refuse to answer
2)< 2,500	5) 10,000 – 14,999	8) don't know
3)2,500 – 4,999	6) > 15,000	

38.
39. Counselling

5. What materials did the counsellor use during the session? (may be more than 1)

   No materials
   Video
   Pictures
   Leaflets

6. When did you receive information about PMTCT?
   During this pregnancy
   Before this pregnancy

7. Where did you get this information? (may be more than 1)
   Health center
   Hospital
   Friends, relatives
   Village health workers
   Media
   Monks
   Other, please describe

Satisfaction with HIV counselling

8. Were you satisfied that you had **adequate information** to make a decision about HIV testing?
   Yes, enough information
   Yes, partially satisfied but would have liked more information
   Counsellor made the decision for me
   No, not enough information

9. Did you feel you had **adequate time** with the counsellor to get all the information you wanted to know? Yes No Unsure

10. Did you feel you could ask the counsellor questions if you wanted to?
    Yes, could ask anything
    Yes, but could not ask some questions
    Yes, but with difficulty
    No

11. Do you wish you had a different counsellor?
    No Yes
    If yes , different sex older younger
    other please explain _____

12. **If a friend or relative were pregnant, would you recommend** that she came HIV testing? Yes No
    Why?_____

13. **Would you recommend** the HIV testing to any one else? No Yes
If yes, partner friend family member other

14. **Have you recommended** HIV testing to any one else? No Yes
If yes, partner friend family member other

Understanding of basic counselling contents

15. Do you think a man can get infected by having sex with a woman who has HIV?
    Yes No Unsure

16. Do you think a woman can get infected by having sex with a man who has HIV?
    Yes No Unsure

17. Do you think that condom use during sex with an HIV infected partner can prevent HIV transmission? Yes No Unsure

18. Do you think women with HIV infection can infect their babies with HIV **during pregnancy and labour**? Yes No Unsure

19. Do you think women with HIV infection can infect their babies with HIV **through breastfeeding**? Yes No Unsure

20. Do you think there are medicines which HIV infected mothers can take during pregnancy to prevent HIV infections in their babies? Yes No Unsure

21. Why are you offered an HIV test when you are pregnant? (may be more than 1)
    So that I can find out my HIV status
    To receive medicines to prevent my baby being HIV positive
    To receive formula to prevent my baby being be HIV positive
    To discontinue pregnancy when I am HIV positive
    I do no know
    Other , Please explain _____

22. Did you consent *freely* to HIV testing?
    Yes Yes, but not completely freely No
23. Will you return to collect your HIV test result? Yes No Don't know

Disclosure and partner testing

24. Have you discussed HIV testing with your partner/boyfriend/husband?

Yes No Don't have partner

25. If you have a partner, has he had an HIV test? Yes € **No** € **Don't know** €

Tool 10
for evaluating HIV NEGATIVE mothers view and understanding of contents in HIV post-test counselling and ongoing counselling

Respondents = HIV negative mothers 1 – 12 months after delivery will be appointed to return for the interview post delivery

Interviewer	Date
Code No. _____ Name of Hospital_____ Province _____	
Regional hospital Provincial hospital District hospital	Region _____ Province _____ District _____
Date of delivery (dd/mm/yyyy)	Hospital of delivery

Introduction
Good morning! My name is _____. I am from the Ministry of Public Health. We are working within Programme for the Prevention of HIV Transmission from Mother to Child. We would like you to answer some questions. Learning about your experiences is very important. It will help the Ministry of Public Health to improve the programme.
You do not have to answer any question if you do not want to and you can stop the interview at any time.
The information you give is confidential. The nurses, doctors and other people will not be told what you said.

Demographic information

1. Age ____

2. Date of delivery _____

3. What is the highest educational level you completed?
   Less than primary
   Primary
   Junior high
   High school
   Basic vocational
   Advanced vocational
   College or higher

4. Would you say you are currently
   Single
   Together with your husband/partner

If single, is this because you are
   Separated
   Widowed
   Never married
   Other, please describe_____

5. What is your total family income (approximately)?

1)None	4) 5,000 – 9.999	7) Refuse to answer
2)< 2,500	5) 10,000 – 14,999	8) don't know
3)2,500 – 4,999	6) > 15,000	

40.

41. Counselling

6. When did you receive information about PMTCT?
   - During this pregnancy
   - Before this pregnancy

7. Where did you get this information? (may be more than 1)
   - Health center
   - Hospital
   - Friends, relatives
   - Village health workers
   - Media
   - Monks
   - Other, please describe

8. When did you first learn you were **not infected with HIV**?
   - During this pregnancy
   - Before this pregnancy

9. How long did it take from the time you were tested to get your test results?
   - Same day
   - 1 day – 1 week
   - 1 –2 weeks
   - > 2 weeks
   - Can't remember

10. Were you able to see the same counsellor for discussion both before and after the test? Yes No Do not remember

Satisfaction with counselling

11. Did you **consent *freely*** to HIV testing?
    Yes Yes, but not completely freely No

12. At pre-test counselling did you feel you had adequate information to **make a decision about HIV testing**? Yes No Unsure

13. At post-test counselling did you feel you received sufficient information to understand what **the test result meant**?
    Yes No Unsure

14. Did you feel you received sufficient information to understand about **the risk of transmitting HIV from mother to baby**? Yes No Unsure

15. During your counselling sessions did you feel you could **ask the counsellor/s questions if you wanted to**?
    Yes, could ask anything
    Yes, but could not ask some questions
    Yes, but with difficulty
    No

16. For your pre-test counselling do you wish you had a different counsellor?
    No Yes
    If yes , different sex older younger
    other please explain _____

17. **If a friend or relative were pregnant, would you recommend** that she came HIV testing? Yes No
    Why?_____

18. **Would you recommend** HIV testing to any one else? No Yes
    If yes, partner friend family member other

19. **Have you recommended** HIV testing to any one else?No Yes
    If yes, partner friend family member other

Understanding of Basic counselling contents

20. Do you think a man can get infected by having sex with a woman who has HIV?
    Yes No Unsure

21. Do you think a woman can get infected by having sex with a man who has HIV?
    Yes No Unsure

22. Do you think that condom use during sex with an HIV infected partner can prevent HIV transmission? Yes No Unsure

23. Do you think women with HIV infection can infect their babies with HIV **during pregnancy and labour**? Yes No Unsure

24. Do you think women with HIV infection can infect their babies with HIV **through breastfeeding**? Yes No Unsure

25. Do you think there are medicines which HIV infected mothers can take during pregnancy to prevent HIV infections in their babies? Yes No Unsure

26. Why are you offered an HIV test when you are pregnant?
    So that I can find out my HIV status
    To receive medicines to prevent my baby being HIV positive
    To receive formula to prevent my baby being HIV positive
    To discontinue pregnancy when I am HIV positive
    I do no know
    Other , Please explain _____

Partner disclosure and testing

27. Have you discussed HIV testing with your partner/boyfriend/husband?
Yes No No partner

If you have a partner, has he been tested? Yes No Don't know No partner

Family planning

28. Are you planning to have another baby? Yes No Don't know

29. Would you agree to HIV testing again during your next pregnancy?
Yes No Do not plan to get pregnant

30. Have you made any plans for family planning since delivery? Yes No
    If yes, please tick box below
    Tubal ligation
    Oral hormonal contraceptive
    Depo Provera
    Norplant
    IUD
    Condom
    Others please explain_____

31. Have you re-started sexual activities since delivery? Yes No

32. If yes, have you used a condom during sex with your partner since delivery?
    Always Sometimes Never

Infant feeding

33. How have you been feeding your baby
    Formula feeding
    Breast feeding
    Mixed (breast and formula)

Tool 11
for evaluating HIV POSITIVE mothers view and understanding of contents in HIV post-test counselling and ongoing counselling

Respondents = HIV positive mothers 1 – 12 months after delivery will be appointed to return for the interview post delivery

Interviewer	Date
Code No. _____ Name of Hospital_____ Province _____	
Regional hospital Provincial hospital District hospital	Region _____ Province _____ District _____
Date of delivery (dd/mm/yyyy)	Hospital of delivery

Introduction
Good morning! My name is _____. I am from the Ministry of Public Health. We are working within Programme for the Prevention of HIV Transmission from Mother to Child. We would like you to answer some questions. Learning about your experiences is very important. It will help the Ministry of Public Health to improve the programme.
You do not have to answer any question if you do not want to and you can stop the interview at any time.
The information you give is confidential. The nurses, doctors and other people will not be told what you said.

Demographic information

1. Age ____

2. What is the highest educational level you completed?
   Less than primary
   Primary
   Junior high
   High school
   Basic vocational
   Advanced vocational
   College or higher

3. Would you say you are currently
   Single
   Together with your husband/partner

If single, is this because you are
   Separated
   Widowed
   Never married
   Other, please describe_____

4. What is your total family income (approximately)?

1) None	4) 5,000 – 9.999	7) Refuse to answer
2) < 2,500	5) 10,000 – 14,999	8) don't know
3) 2,500 – 4,999	6) > 15,000	

42. Counselling

5. When did you receive information about PMTCT?
   - During this pregnancy
   - Before this pregnancy

6. Where did you get this information? (may be more than 1)
   - Health center
   - Hospital
   - Friends, relatives
   - Village health workers
   - Media
   - Monks
   - Other, please describe

7. When did you first learn you **were infected with HIV**?
   - During this pregnancy
   - Before this pregnancy

How long did it take from the time you were tested to get your test results?
- Same day
- 1 day – 1 week
- 1 –2 weeks
- > 2 weeks
- Can't remember

8. Were you able to see the same counsellor for discussion both before and after the test? Yes No Do not remember

Satisfaction with counselling

9. Did you **consent *freely*** to HIV testing?
   Yes No Yes, but not completely freely

10. At pre-test counselling did you feel you had sufficient information to **make a decision about HIV testing**? Yes No Unsure

11. At post-test counselling did you feel you received sufficient information to understand what **the test result meant**? Yes No Unsure

12. Did you feel you received sufficient information to understand about **how to reduce the risk of infecting your baby**? Yes No Unsure

13. Did you feel you received sufficient information to understand about what **HIV infection means for your own health**? Yes No Unsure

14. Did you feel you received sufficient information about other **health and social services** that were available to you? Yes No Unsure

15. During the counselling sessions did you feel you could **ask the counsellor/s questions if you wanted to**?
    Yes, could ask anything
    Yes, but could not ask some questions
    Yes, but with difficulty
    No

16. Please think of the room where you received counselling about your test result? Was this a satisfactory space for a private discussion?
    Yes No Unsure

17. Did you feel that the information about your test would be kept private?
    Yes No Unsure

18. Do you regret having had an HIV test? Yes No Unsure

19. Do you wish you had a different counsellor?
    No Yes
    If yes , different sex older younger
    other please explain _____

20. **If a friend or relative were pregnant, would you recommend** that she came HIV testing? Yes No
    Why?_____
    _

21. **Would you recommend** HIV testing to any one else? No Yes
    If yes, partner friend family member other

22. **Have you recommended** HIV testing to any one else?No Yes
    If yes, partner friend family member other

Understanding of Basic counselling contents

23. Do you think a man can get infected by having sex with a woman who has HIV?
    Yes No Unsure

24. Do you think a woman can get infected by having sex with a man who has HIV? Yes
    No Unsure

25. Do you think that condom use during sex with an HIV infected partner can prevent HIV transmission? Yes No Unsure

26. Do you think women with HIV infection can infect their babies with HIV **during pregnancy and labour**? Yes No Unsure

27. Do you think women with HIV infection can infect their babies with HIV **through breastfeeding**? Yes No Unsure

28. Do you think there are medicines which HIV infected mothers can take during pregnancy to prevent HIV infections in their babies?
    Yes No Unsure

29. Why are you offered an HIV test when you are pregnant?
    So that I can find out my HIV status
    To receive medicines to prevent my baby being HIV positive
    To receive formula to prevent my baby being HIV positive
    To discontinue pregnancy when I am HIV positive
    I do no know
    Other , Please explain _____

Confidentiality

30. Did anyone find out you had HIV without you telling them?
    No Yes
    If yes, who? _____
    And how do you think they found out? _____

31. Do you think someone might find out a woman was HIV positive because she was taking ZDV? Yes No

32. Do you think that someone might find out a woman was HIV positive because she was formula feeding? Yes No

33. Have you experienced any physical violence from your husband/partner in the last 5 years or so – like being hit or struck? Yes No

    If yes, Do you think this was ever because of your HIV infection?
    Yes No Do not know

43. Coping

34. A lot of people find it very hard when they find out their test was positive. After you found out your test result, did you ever have feelings that were hard to cope with? Yes No

35. Sometimes when people are feeling really sad, they think about ways to hurt themselves and sometimes about killing themselves. At the worst times, did you ever have thoughts like this? Yes No

36. Have you ever tried to hurt yourself? Yes No

37. Has anyone helped you through these difficult times? Yes No

38. If yes, who helped you? (may be more than 1)
    Counsellor
    Nurse
    Doctor
    Partner
    Family
    Friend
    Community organization
    NGO
    No one
    Other , Please explain _____

ZDV

39. Did you take any ZDV during this pregnancy? Yes No

40. Did you *want* to take ZDV during this pregnancy, but did not take it?
Yes No

Partner disclosure and testing

41. Have you discussed HIV testing with your partner/boyfriend/husband?
Yes No No partner

If you have a partner, has he been tested? Yes No Don't know No partner

Family Planning

42. After you found out you were HIV infected, did you ever want to end your pregnancy?
Yes No

43. Are you planning to have another baby? Yes No Don't know

44. Have you made any plans for family planning since delivery?

If yes, please tick box below	No	Yes
Tubal ligation		
Oral hormonal contraceptive		
Depo Provera		
Norplant		
IUD		
Condom		
Others please expand_____		

45. Have you re-started sexual activities since delivery? Yes No
If yes, have you used condoms during sex with your partner since delivery?
Always Sometimes Never

Infant feeding

46. How have you been feeding your baby
Formula feeding
Breast feeding
Mixed (breast and formula)

Referral for HIV health assessment and management

47. Have you had an assessment of HIV health related problems at any time since testing
HIV positive No Yes
If yes, when ? (may be more than 1)
Immediately after receiving HIV positive test result
During follow up ANC visits
Post Partum check
During Well Baby Clinic visits

Only when having symptoms

If yes, were you recommended regular follow up for your clinical status of HIV infection from time of diagnosis until the future Yes No

If yes, were you explained about PCP prophylaxis? Yes No

If yes, were you explained about symptoms of tuberculosis? Yes No

If yes, were you explained about symptoms of opportunistic infections? Yes No

Infant care

48. Has your baby been tested for HIV or are plans made for testing the baby? Yes No

49. Has your baby have an assessment of HIV related health problems at any time since disclosure of HIV positive test result No Yes

If yes, when_____

50. Has your counsellor referred you to any support group for yourself or your baby? Yes No

Needs

51. At the moment do you have any of the following problems (may be more than 1):

Your own health		Yes	No
Having a place to live		Yes	No
Looking after you child or children		Yes	No
Having enough money to live	Yes	No	
Caring for a sick person		Yes	No
Your relationship with husband/ partner	Yes	No	No partner
Your relationship with family		Yes	No
Other problems	Yes	No	

Please give details

_____

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